



GEORGIA HEALTH LAW DEVELOPMENTS

A PUBLICATION OF THE HEALTH LAW SECTION OF THE STATE BAR OF GEORGIA

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MESSAGE FROM THE CHAIR

Greetings Health Law Section Members,

It has been an exciting year to be a health care lawyer. Each week brought word of new rules, new policy debates or even new statutory changes. And this monumental rate of change is far from over.

The Health Law Section remains committed to providing you, our members, with up-to-date information, as well as opportunities to participate in Section committees and activities. In addition to our annual Fundamentals of Health Law seminar (thanks again to the chair Rod Meadows for putting on a great program) and our annual Advanced Health Law Seminar, coming up on October 14, 2011 at the Four Seasons Hotel in Atlanta, the Executive Committee has been working to coordinate an event on the campus of the Centers for Disease Control and Prevention in Atlanta, providing more information about the CDC and its involvement with significant health law issues in Georgia and around the world (thanks to Alan Rumph for taking the lead on this event). We are hoping to get this exciting event scheduled for early 2012 so please keep an eye out for more details.

Much appreciation goes to all of the authors who contributed to this Summer's newsletter. In this edition, Lynn Adam informs of DOJ efforts to detect improper billing associated with defibrillator services, Alan Rumph and Reid Pearlman give an update on physician compliance with the new Health Care law and Brian Stimson provides insight into the effects of Georgia's Medicaid Care Management Organization Act. Thanks to Brian McEvoy for his assistance in publishing the newsletter.

Finally, many thanks to Stan Jones and Helen Sloat for their effort in preparing the Healthcare Legislative Report, summarizing health care activities this year under the Gold Dome.

The Executive Committee continually seeks to prepare meaningful programs for our Section and provide you with information relevant to the practice of health care and we hope that you have benefited from these efforts. We invite our members to submit articles, reports, and proposals for presentations that would be informative to the membership.

It is an honor to serve as Chair this year. Please let me or anyone on the Executive Committee know if you have any ideas or suggestions to help us better serve you.

Best regards,

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DOJ Probes Defibrillator Billing

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The United States Department of Justice (DOJ) is investigating whether numerous hospitals around the country submitted claims for implantable defibrillators that potentially violated Medicare coverage policy. The probe encompasses thousands of claims dating back to 2003, each reflecting Medicare reimbursement rates of up to approximately \$45,000 per claim. Georgia hospitals that have not received a notice from DOJ may not be out of the woods yet, as the scope of the investigation may expand.

Nationwide probe

In March 2010, DOJ initiated the inquiry into defibrillator billing when it issued Civil Investigative Demands under the False Claims Act to numerous hospitals, hospital chains, and device manufacturers. DOJ broadened the probe later in the year by delivering letters to additional hospitals stating their defibrillator claims were also under review. The letters cite a Medicare National Coverage Determination (NCD) that sets forth coverage criteria of implantable defibrillators, and they assert that a preliminary claims analysis indicates that some claims were excluded from coverage. At this writing, the Government has not resolved the matter with any of the hospitals involved in the probe.

Defibrillators

An implantable cardioverter defibrillator (sometimes known as an ICD or AICD) is surgically inserted in the chest of the patient to prevent sudden cardiac death. When the device detects a life-threatening irregular heart rhythm (arrhythmia), it delivers an electric shock to restore the heart's natural rhythm. In many

cases, a patient receives a defibrillator and a pacemaker in a single small device. The combination machine not only corrects arrhythmias, but it also continues to deliver electric pulses to stimulate healthy pacing in the heart.

An electrophysiologist typically determines when a defibrillator or combination device is indicated and performs the implantation procedure, and the hospital follows the physician's order. Nonetheless, the DOJ inquiry thus far centers on hospital billing.

DOJ's Focus

The high cost and frequency of the procedure probably explain DOJ's scrutiny of these claims. The Government is focused on one particular aspect of the NCD coverage rules. The policy states that a patient generally (with exceptions) is *not* eligible for a defibrillator within 40 days of experiencing an acute myocardial infarction (a heart attack) or within 3 months of undergoing angioplasty or bypass surgery. Federal investigators used basic data mining to identify defibrillator implant dates that fell within the 40-day/3-month prohibited window.

DOJ created a spreadsheet of Medicare claims falling within those time periods and supplied it to each hospital under investigation. The hospitals now are grappling with developing medical and legal defenses to any potential False Claims Act liability.

Challenges for Hospitals

DOJ attorneys readily acknowledge that their data mining did not take into account several

medical indications described in the NCD that are *not* subject to the 40-day/3-month prohibition. Hospitals are left with the job of determining which of the challenged claims relate to patients with those indications, such as a personal history of sudden cardiac arrest. The analysis of which claims meet or do not meet the coverage criteria is complicated by the detailed, nuanced, and in some respects, ambiguous language of the NCD.

Moreover, even claims that technically violated the NCD may be defensible (at least in the setting of a False Claims Act investigation) because the circumstances reflect the exercise of sound medical judgment. The NCD does not expressly allow coverage based solely on a physician's judgment of medical necessity. However, an electrophysiologist may encounter any number of circumstances justifying an implantable defibrillator even when the device is not technically covered within the four corners of the NCD.

Given the confluence of the foregoing factors and the potential for consideration by the Government of False Claims Act theories of liability, many hospitals are conducting an expensive but necessary case-by-case medical review of each patient record. DOJ attorneys have expressed a willingness to discuss the medical conditions of individual patients involved in the investigation.

Proactive Measures

Hospitals fortunate enough not to be subjected to the DOJ probe thus far may want to take steps now to evaluate any potential problems in this area and to be able to demonstrate in the future they made voluntary, proactive compliance efforts. Among other measures to consider, a hospital could perform an internal audit of a sample of defibrillator claims submitted to Medicare -- under the supervision of counsel and within the attorney-client privilege -- and could implement a pre-procedure process to assess Medicare coverage of every defibrillator ordered by the physician.

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COMPLYING WITH THE NEW HEALTH CARE REFORM LAW: A PRESCRIPTION FOR SUCCESS

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The health care "reform" law, formally titled the Patient Protection and Affordable Care Act (PPACA), includes a number of provisions designed to encourage compliance with federal government payor rules. This article provides a brief, selected overview of several key provisions, along with some practical suggestions for physician practices.

I. Mandatory Compliance Plans

One provision of the PPACA prescribes mandatory health care compliance plans. Although the law only specifically requires compliance plans for nursing homes, it gives the Secretary of Health and Human Services (HHS) broad discretion to

mandate that other types of providers maintain compliance programs. Many in the industry expect that HHS will soon require that all physicians have compliance plans in place. In the recently released "Roadmap for Avoiding Medicare and Medicaid Fraud and Abuse," the HHS Office of Inspector General (OIG) stated: "With the passage of the Patient Protection and Affordable Care Act of 2010, physicians who treat Medicare and Medicaid beneficiaries will be required to establish a compliance program."¹

¹ Although the OIG targeted new physicians with the Roadmap, all physicians should read this excellent summary of the most important fraud and abuse

Although compliance plans remain voluntary for physicians (at least for now), an effective compliance program is strongly recommended for all physician practices, since these plans not only reduce mistakes, but also tend to minimize potential penalties for non-compliance. *Effective* is the critical word. A compliance plan should not be a “canned” or “off the shelf” document that is adopted and then just filed away. Such plans can actually create more problems than they solve, because a practice’s failing to follow its own plan can be evidence of “bad intent” if compliance problems do occur. In fact, an effective program is really about a process, specifically tailored to and “operationalized” by the practice, which is designed to ensure compliance with a range of federal health care requirements, including coding and billing rules, the self-referral or “Stark” law, the anti-kickback statute, and the anti-markup rule for diagnostic tests.²

II. Reporting and Returning Overpayments

Another important PPACA provision requires reporting and repayment of any overpayment under a federal health care program within 60 days after the overpayment is “identified.” Although the law does not define “identified,” one should expect the government to apply this provision to physicians and other providers who know or have reason to know that they have been overpaid and who then fail to quantify, report and return the overpayment.

The new law states that failure to report and return overpayments within the 60 days potentially subjects providers to penalties under the federal False Claims Act and Civil Monetary

provisions. The Roadmap is available on the OIG’s Web site at

http://oig.hhs.gov/fraud/PhysicianEducation/roadmap_web_version.pdf.

² The OIG has published compliance program guidance for physicians, which is available on its Web site at <http://oig.hhs.gov/authorities/docs/physician.pdf>. It has also published general provider compliance training materials as part of its Health Care Fraud Prevention and Enforcement Action Team (HEAT) activities at <http://oig.hhs.gov/compliance/provider-compliance-training/index.asp>.

Penalties law. Depending upon the type of overpayment, these laws provide for penalties ranging up to \$15,000 *per claim*. These penalties can now apply even if the initial billing or other conduct that resulted in the overpayment was unintentional or even reasonable when it actually occurred. This situation is especially threatening because private individuals can act as “whistleblowers” and receive a share of the penalties under the False Claims Act. The PPACA further exacerbated the problem by expanding recent changes to the False Claims Act that make it easier for individuals (e.g., disgruntled employees or competitors) to bring successful whistleblower suits.

III. Stark Considerations

A. Overview

Inadvertent violations of the Stark law are particularly dangerous under the new overpayment provisions. Stark is a “strict liability” statute, which means that any Medicare (and perhaps Medicaid) claim billed in violation of Stark is an improper claim and must be repaid, regardless of how reasonable or well intended the claim was when filed. Thus, a service that is medically necessary, properly documented, and fulfills all other Medicare requirements generally applicable for payment automatically becomes an improper claim and creates an overpayment subject to the new law, if it arises out of an arrangement or structure that Stark prohibits.

Although the technical details of Stark are beyond the scope of this article, one rule deserves brief mention: Many physicians are surprised to learn that Stark regulates how the members a single medical practice may share the revenues or profits from services to which Stark applies (which are called “designated health services,” or DHS—such as radiology or other imaging, radiation therapy, clinical laboratory or anatomic pathology services, physical or occupational therapy, speech pathology, durable medical equipment, prosthetics and orthotics, and outpatient prescription drugs). If a physician practice distributes any of its revenues or profits from DHS in a manner that does not comply with Stark’s potentially byzantine rules, then all Medicare (and perhaps Medicaid) DHS provided by the practice may constitute invalid claims subject to the overpayment law.

B. Patient Disclosure of Alternative CT, MRI and PET Service Options

PPACA also enacted a new patient disclosure requirement for physicians that provide CT, MRI or PET scans through their practices. Effective January 1, 2011, physicians must provide each patient with written notice, at the time *each* scan is ordered, that the patient may receive the scan from another source. The notice must list the name, address and telephone number of at least five alternate “suppliers” for the service located within a 25-mile radius of the referring physician’s office. If there are fewer than five alternate suppliers within 25 miles, then the notice must list all of the suppliers within that radius. CMS defined “suppliers” strictly, which generally means other physician practices and free-standing imaging centers. Hospitals and hospital departments, which are deemed “providers” and not “suppliers” under the Medicare law, may be included in the list, but *they do not count toward the five required suppliers*.

Again, however technical the violation, claims billed in violation of Stark are invalid. This new patient disclosure requirement is thus a potential trap for unwary physicians—and a potential windfall to whistleblowers.

C. CMS Self-Disclosure Protocol

In light of the harsh nature of Stark, one PPACA provision was at least potentially favorable for physicians: the Self-Referral Disclosure Protocol (SRDP), under which physicians, hospitals, and other Medicare participants may disclose actual or potential Stark violations and hopefully reasonably settle those claims.³ Although the SRDP was eagerly anticipated by the industry, CMS offers no promises and little encouragement that it might be flexible in settling Stark violations. Indeed, CMS’s threats of referral to the OIG or Department of Justice, as well as onerous reporting requirements, may well dissuade most from pursuing the SRDP option. It thus remains to be seen whether the SRDP will be a valuable tool for resolving Stark issues or yet another landmine facing physicians.

³ The SRDP is available at http://www.cms.gov/PhysicianSelfReferral/Downloads/6409_SRDP_Protocol.pdf.

IV. Conclusion

In light of the PPACA, there is little doubt that physicians should step up their federal program compliance efforts. Practices, however, should exercise care when implementing new compliance activities. As previously noted, inappropriate compliance plans or plans that are not completely followed can do more harm than good. Moreover, coding and billing audits and Stark consultations may uncover actual or potential overpayments from previously filed claims. Auditors or consultants may make statements in reports that could support the conclusion that an overpayment has been “identified,” even if that conclusion has not been confirmed. Such reports are generally freely discoverable by the government or whistleblowers in enforcement actions.

Practices should therefore engage a seasoned health care attorney *before* engaging compliance auditors or consultants, so that any resulting reports or other communications might be protected from discovery by the attorney-client or attorney work product privilege. A skilled attorney might also find that an overpayment does not clearly exist or at least be able to defer the point at which the overpayment may be deemed “identified” (and therefore repayable) under the PPACA reporting rules.

The Scope of Discovery in Health Care Payment Arbitrations Under Georgia's Medicaid Care Management Organization Act

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In 2006, the Georgia Department of Community Health (“DCH”) implemented a Medicaid managed care program. That program administers Medicaid benefits through three private Medicaid Care Management Organizations (“MCMOs”). The majority of Medicaid beneficiaries in Georgia now receive their benefits through such entities, instead of the traditional fee-for-service program.

Two years after DCH implemented the Medicaid managed care program, the Medicaid Care Management Organization Act became law. The Act authorizes providers contracted with MCMOs⁴ to demand binding, private arbitration of denied or underpaid claims after exhausting the MCMOs’ internal appeals processes.⁵ The private arbitrator must be certified by a nationally recognized association that provides training and certification in alternative dispute resolution. *Id.* If the MCMO and the provider are unable to agree on an association, then the rules of the American Arbitration Association (“AAA”) apply. *Id.* The arbitrator must have experience and expertise in the health care field and be selected according to the rules of his or her certifying association. *Id.* Additionally, the arbitrator must conduct a hearing and also issue a final ruling within 90 days of being selected, unless the MCMO and the provider agree otherwise. *Id.*

The Act’s 90-day period for arbitration is a fast track that allows only a short time for hearing preparation and presentation. The expedited schedule tends to favor the party which needs discovery the least. And when the dispositive issue is the interpretation of a substantive contractual provision, the party that needs discovery the least

is often the one with the better argument on the face of the contract. Yet even when the text favors one side, both parties have incentives to agree to a longer arbitration, including one with limited or even litigation-style discovery. For example, the parties may want discovery in order to resolve fact issues regarding compliance with the disputed contractual provision, or the claims submission requirements set forth in the MCMO contract and administrative guide.

Regardless of how long the arbitration is, the parties must resolve issues regarding the scope of discovery. Because MCMO arbitrations are creatures of both the Act and the MCMOs’ contracts with providers, the threshold legal question is often whether the Federal Arbitration Act (“FAA”) or state law, including the Georgia Arbitration Code (“GAC”), governs the scope of discovery. The application of the FAA instead of state law can greatly impact the discovery available to the parties, especially non-party discovery.

Does the FAA govern the scope discovery in arbitrations under the MCMO Act?

The FAA should govern the scope of discovery when the MCMO contract contains an arbitration clause. The FAA preempts state law when a contract with an arbitration clause evidences a transaction involving interstate commerce.⁶ Several courts have held that a managed care contract evidences such a transaction if the managed care entity transmits eligibility or claims information across state lines when performing the contract.⁷ Presumably, the MCMOs administering

⁴ The MCMOs are fully-captitaded state contractors and not third-party administrators (“TPAs”) for DCH. The providers’ contracts with the MCMOs are essentially subcontracts, to which DCH is not a party.

⁵ O.C.G.A. § 33-21A-7(b).

⁶ 9 U.S.C. § 2.

⁷ See, e.g., *Health Ins. Corp. of Ala. v. Smith*, 869 So. 2d 1100, 1105 (Ala. 2003) (mailing policy application to out-of-state TPA); *Webb v. Am. Employers Group*, 684 N.W.2d 33, 39 (Neb. 2004) (sending claims to WI and performing precertification in CA).

Georgia's Medicaid program transmit such information across state lines because they are corporate affiliates of national managed care companies.⁸ If the MCMOs indeed conduct business across state lines, then the MCMO contracts trigger FAA preemption.

Even if the MCMOs do not transmit information or process transactions across state lines, the Medicaid program was created by Congress using the Commerce Clause power, and any MCMO contract should evidence a transaction involving interstate commerce on that basis alone.⁹ The FAA thus preempts any Georgia law (including the GAC) which conflicts with the FAA's provisions or undermines enforcement of the arbitration clauses in MCMO contracts.¹⁰ Such laws include those which prescribe conflicting discovery procedures.¹¹

Preemption should also result when the MCMO contract contains an express provision requiring the parties to comply with the Act. Such a provision should be sufficient to incorporate the Act's arbitration language by reference.¹² Because the Act requires the MCMO to arbitrate upon receiving a demand from a provider, a contract

⁸ The MCMOs are WellCare, Amerigroup Community Care, and Peach State Health Plan. WellCare's ultimate parent company, WellCare Health Plans, Inc., is headquartered in Tampa, Florida. Amerigroup Community Care's ultimate parent company, Amerigroup Corporation, is headquartered in Virginia Beach, Virginia. Peach State Health Plan's ultimate parent company, Centene Corporation, is headquartered in St. Louis, Missouri.

⁹ *Univ. of S. Ala. Found. v. Walley*, No. Civ. A. 99-D-1287-N, 2001 WL 237 237309, at *3-5 (M.D. Ala. Jan. 30, 2001).

¹⁰ *Langfitt v. Jackson*, 644 S.E.2d 460, 465 (Ga. Ct. App. 2007) (citing *Southland Corp. v. Keating*, 465 U.S. 1, 16 (1984)).

¹¹ *In re Beck's Superior Hybrids, Inc.*, 940 N.E.2d 352, 367-68 (Ind. App. 2011).

¹² *Hembree v. Johnson*, 482 S.E.2d 407, 408 (Ga. Ct. App. 1997) ("Incorporation by reference is ... effective to accomplish its intended purposes where ... the reference has a reasonably clear and ascertainable meaning"); see *Grady Cnty. Bd. of Educ. v. Hickerson*, 571 S.E.2d 391 (Ga. 2002) (finding that contract incorporated statutory dispute resolution provisions).

provision that incorporates the Act should function as an arbitration clause and trigger FAA preemption of inconsistent state laws.¹³

What is the scope of party discovery in MCMO arbitrations under the FAA?

The FAA does not place any limits on party discovery, nor does the MCMO Act. The FAA grants the arbitrator broad discretion to control party discovery within the limits set by the arbitration clause.¹⁴ When the arbitration clause does not expressly limit party discovery, and instead incorporates arbitration rules by reference, the arbitrator usually retains at least some discretion to manage party discovery.

For example, the AAA commercial rules require the parties to exchange copies of all exhibits before the hearing.¹⁵ The arbitrator "may" also direct the parties to produce documents and other information, and identify the witnesses to be called.¹⁶ The arbitrator then resolves any disputes regarding the exchange.¹⁷ The AAA commercial rules authorize broad, litigation-style discovery only in large, complex cases involving a claim of at least \$500,000.¹⁸ The commercial rules empower

¹³ Theoretically, a MCMO could include an arbitration clause in the contract that is both separate from, and inconsistent with, the contract provision incorporating the Act's arbitration language. The FAA would then preempt the Act, even though the Act authorized arbitration in the first place. Of course, that dilemma is unlikely because state law prohibits the MCMOs from entering into contracts which are inconsistent with the Act. O.C.G.A. § 33-21A-10(b). Presumably, the MCMOs must also obtain DCH approval of their contracts before executing the contracts with providers.

¹⁴ *First Preservation Capital, Inc. v. Smith Barney, Harris Upham & Co., Inc.*, 939 F. Supp. 1559, 1565 (S.D. Fla. 1996); *Scurtu v. Int'l Student Exch.*, No. 07-0410-WS-B, 2008 WL 2669270, at *1 (S.D. Ala. Jun. 30, 2008) (citing *Suarez-Valdez v. Shearson Lehman/Am. Express, Inc.*, 858 F.2d 648 (11th Cir. 1988)).

¹⁵ AAA R-21.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ AAA Commercial Arbitration Rules and Mediation Procedures – Table of Contents.

the arbitrator to “establish the extent of the discovery” in large, complex cases when the parties cannot agree on scope.¹⁹ For good cause shown, the arbitrator “may” allow depositions and interrogatories.²⁰

While the AAA commercial rules have long governed managed care disputes, the AAA recently issued new “Healthcare Payor Provider Arbitration Rules,” which became effective on January, 31 2011.²¹ The healthcare rules establish three case tracks: (1) regular, (2) desk, and (3) complex. Managed care cases are automatically placed on the regular track unless the parties agree otherwise.²² The regular track provides for the same information exchange as the standard commercial rules, plus one deposition by each party, unless the parties agree to, or the arbitrator orders more depositions “for good cause shown.”²³ The desk track does not allow any discovery “absent extraordinary circumstances and a finding of good cause”²⁴ In contrast, the complex track requires the parties to exchange documents within their control if the arbitrator deems it to be consistent with “a just, speedy, and cost effective resolution.”²⁵ Only two depositions are allowed unless the parties agree to, or the arbitrator orders more depositions “for good cause shown.”²⁶ The arbitrator may also order interrogatories “for good cause shown.”²⁷

¹⁹ AAA L-4(c).

²⁰ AAA L-4(d).

²¹ The AAA healthcare rules apply only if the arbitration clause in the contract specifically provides for the use of the AAA healthcare rules, or the parties agree to use the AAA healthcare rules after the filing of the demand. AAA Healthcare Payor Provider Arbitration Rules at p.8. Otherwise, the AAA commercial rules apply.

²² AAA R-1(d).

²³ R-19, R-20.

²⁴ AAA D-4.

²⁵ AAA C-5(b).

²⁶ AAA C-4.

²⁷ AAA C-5(c).

Under the AAA commercial or healthcare desk rules, an arbitrator may prohibit discovery and permit only the exchange of exhibits. Because an order prohibiting discovery would conflict with the GAC, which entitles a party to receive the other party’s witness list and examine the other party’s documents,²⁸ the FAA should preempt the GAC. The party seeking the additional discovery would have no recourse against the order, as the federal courts can only vacate arbitration awards if the arbitrator engaged in misconduct or exceeded his or her powers.²⁹ Since the arbitrator has discretion to manage party discovery under the FAA and most arbitration rules, and the FAA permits only limited judicial review of arbitration awards (as opposed to discovery orders), the parties must be mindful of their potential discovery needs when negotiating the arbitration clause and selecting the controlling arbitration rules.

What is the scope of non-party discovery in MCMO arbitrations under the FAA?

The scope of discovery presents more interesting questions when the parties seek the discovery from non-parties, such as corporate affiliates, former employees, third-party vendors (e.g., data warehouses), and expert witnesses. This is because the literal language of the FAA authorizes only the arbitrator to subpoena non-parties to appear at hearing to either testify or present documentary evidence:

The arbitrators selected either as prescribed in this title or otherwise, or a majority of them, may summon in writing any person to attend before them or any of them as a witness and in a proper case to bring with him or them any book, record, document, or paper which may be deemed material as evidence in the case.³⁰

If a witness refuses or fails to respond to the arbitrator’s subpoena, then the arbitrators may seek the U.S. District Court’s assistance in

²⁸ This provision of the GAC is codified at O.C.G.A. § 9-9-9(c).

²⁹ See 9 U.S.C. § 10(a)(1)-(4).

³⁰ 9 U.S.C. § 7.

compelling attendance or punishing the witness for contempt.³¹

The U.S. District Court for the Southern District of Florida has held that the FAA does not authorize attorneys to issue subpoenas to non-parties.³² As a result, counsel must obtain the arbitrator's permission to conduct non-party discovery. The GAC is consistent with the FAA on this issue.³³

The district courts of the Eleventh Circuit disagree on whether the FAA authorizes the arbitrator to issue subpoenas to non-parties before the hearing. The Northern District of Georgia and the Southern District of Florida have joined at least two federal circuit courts in holding that the arbitrator may do so.³⁴ The GAC is consistent with the FAA as interpreted by these courts.³⁵

The opposing view was recently articulated by another district judge from the Southern District of Florida.³⁶ When a court follows the opposing view, the FAA should preempt the GAC. As a practical matter, preemption could prevent parties from obtaining legitimate discovery from nonparties which have a financial or other interest in the outcome of the arbitration. For instance, preemption could prevent a party from discovering documents from a corporate affiliate of the opposing party which the opposing party does not control. While preemption would enhance the

³¹ See *Id.*

³² *Suratt v. Merrill Lynch, Pierce Fenner & Smith, Inc.*, No. 03-80502-CIV, 2003 WL 24166190 (S.D.Fla. Jul. 31, 2003).

³³ See O.C.G.A. § 9-9-9(a) ("The arbitrators may issue subpoenas ...").

³⁴ *Festus v. Helen Stacy Found., Inc. v. Merrill Lynch, Pierce Fenner, & Smith Inc.*, 432 F. Supp. 2d 1375, 1378 (N.D. Ga. 2006); *Stanton v. Paine Webber Jackson & Curtis, Inc.*, 685 F. Supp. 1241, 1242 (S.D. Fla. 1988); see also *Am. Fed'n of Television & Radio Artists, AFL-CIO v. WJBK-TV (New World Commc'ns of Detroit, Inc.)*, 164 F.3d 1004, 1010 (6th Cir. 1999); *In re Sec. Life Ins. Co. of Am.*, 228 F.3d 865, 871 (8th Cir. 2000).

³⁵ See O.C.G.A. § 9-9-9(a).

³⁶ *Kennedy v. Am. Express Travel Related Servs. Co.*, 646 F. Supp.2d 1342, 1344 (S.D. Fla. 2009).

efficiency of the process by reducing non-party discovery, it could frustrate the resolution of the case on the merits if the documents are material.

When pre-hearing subpoenas of non-parties are permitted in arbitration, the subpoenas offer advantages which are not available in state or federal court litigation. This is because the FAA does not place jurisdictional or geographic restrictions on subpoenas.³⁷ Subpoenas issued by arbitrators in Georgia may be served on a non-party anywhere in the United States, regardless of whether the non-party has the minimum contacts required for personal jurisdiction in Georgia. *Id.* The limits on issuing and serving subpoenas set forth in the Federal Rules of Civil Procedure do not apply either. *Id.* Thus, the FAA not only preempts state limits on issuing subpoenas, but also trumps the limits on subpoenas which normally apply in the federal system.

In short, non-party discovery in arbitration must be conducted through the arbitrator. When such discovery is allowed before the arbitration hearing, the arbitrators may exercise greater subpoena power than do courts in litigation.

Conclusion

While the Act authorizes MCMO arbitrations, it is the FAA and not state law that actually governs the arbitrations. The FAA vests the arbitrator with considerable discretion, which is typically preserved (at least in part) by the arbitration rules of organizations such as the AAA. When the arbitrator maintains discretion under the applicable rules, the parties have little recourse against unfavorable discovery rulings. At the same time, the parties can benefit greatly from the far-reaching subpoena power which the FAA vests in the arbitrator. For these reasons, it is critical for the parties to consider their potential discovery needs when negotiating the arbitration clause and choosing the applicable arbitration rules for their contract.

³⁷ *Festus v. Helen Stacy Found., Inc. v. Merrill Lynch, Pierce Fenner, & Smith Inc.*, 432 F. Supp. 2d 1375, 1378 (N.D. Ga. 2006).

Healthcare Legislative Report 2011 Session Georgia General Assembly

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This report summarizes legislation relevant to the health industry that was adopted by the General Assembly in 2011 and signed by Governor Deal. There is also a summary of budget changes that are relevant to the industry. You may see a fuller report on these and other topics, including relevant industry legislation that was introduced but did not pass, on our website, www.nelsonmullins.com under Gold Dome Report. We start with some highlights about the Session overall and then have organized successful legislation by topic.

The 2011 Session of the Georgia General Assembly was the first year of the biennial term 2011-2012, following the 2010 elections. As normally occurs, there were many new Members of the General Assembly, including 38 in the House and 14 in the Senate. Consistent with the huge changes in the Congress, several new Georgia Members were advocates for the Tea Party, limited government, lower taxes and a part of the national reaction to issues such as health care reform proposed by President Obama.

Governor Nathan Deal also began his four-year term on January 10, 2011, and, of course, appointed new Department heads and brought a new political and policy staff to the mix of players under the Gold Dome. Many members of his Congressional staff joined his administration.

Governor Deal's Inaugural Ball was delayed by a freak snow and ice storm, but this beginning did not put a damper on his leadership as he brought fresh energy and perspective to Georgia. Governor Deal's style is different than that of former Governor Sonny Purdue, and he enjoyed positive reactions from the Members of the General Assembly and the lobbying corps.

This style manifested itself initially in the discussion about refinancing Georgia's HOPE scholarship and its Pre-K program funded by the Georgia lottery. The lottery reserves had depleted so that reductions in the amounts of the scholarships and expenses in the Pre-K program were necessary. Governor Deal made one thoughtful proposal to begin the discussion and then accommodated issues raised by the public and the Members of the Legislature. Testy comments, some akin to the energy of the Civil Rights Movement, were made by students at many legislative hearings, but the decline in the lottery proceeds over several years necessitated a reduction in the scholarship amounts for students not sustaining a 3.3 grade point average and a modification in the length and number of the school days for the very successful Pre-K program. The end result was heralded by both parties and signaled a cooperative, listening style from the new Governor.

Many observers noted the common Gainesville roots of the Governor and Lieutenant Governor Casey Cagle and the new era of cooperation among them and the Speaker of the House David Ralston. On the Senate side, however, Senators proposed significant changes to the Lieutenant Governor's traditional power to appoint Committees and their Chairs and to assign bills to Committees. A Committee of eight Senators was enacted in the Senate Rules to make the Committee appointments, and there were moments when the multiple foci of Senate leadership made bargaining more difficult than normal. The Democrats forced a discussion of the process late in the Session, and the eight-person Committee has given way to a Committee of four, two appointed by the Lieutenant Governor. Because bargaining on the contested issues was

not always easy, the Session was probably less active than many previous Sessions in terms of the amount of legislation proposed; perhaps, this lack of activity is also in part because of the public demand for smaller government.

These disputes did not retard consideration of the State's budget, which is a constitutional mandate. It proved fairly easy to pass a budget that reduced State expenditures another \$1.4 billion, necessitated by the expiration of the federal stimulus package provisions that helped states support Medicaid and education budgets. A summary of budget highlights for the departments involved in health and social services is attached at the end of this paper. On a positive note, State tax revenues did begin some recovery in the tail end of the 2011 fiscal year, rising over 2010 collections for the same months. The increase in revenues will replenish State reserves for the first part of the new fiscal year, while policymakers wait to see if the more positive results continue.

The dominant issue during the Session was the effort by the General Assembly to react to the recommendations made by the Special Council on Tax Reform and Fairness for Georgians ("Special Council") which met throughout 2010. This Council had been charged in 2010 with evaluating Georgia's tax structure and making revenue-neutral recommendations to lower the personal and corporate income tax and seeking tax incentives to encourage economic development and predictable tax results for better budget planning. A legislative Committee, the Special Joint Committee on Georgia Revenue Structure, was co-chaired by new House Ways and Means Chairman Mickey Channell (R-Greensboro) and Senate Finance Committee Chairman Bill Heath (R-Bremen), and had the task of presenting a single tax bill to the floors of both chambers that could not be amended on either floor. This process was modeled on the federal military base review and closing panel. Rep. Channell has historically been a strong pro hospital advocate and continued to be involved in Medicaid funding and management.

The Special Council presented multiple recommendations to lower the income tax, sunset all existing sales tax exemptions for re-evaluation as to their benefits, add a new sales tax on consumer services, impose a uniform communications tax that covered satellite services as well as the utilities, and improve revenue collection. These proposals were interlaced to

assure revenue neutrality and cleared with Grover Norquist of Americans for Tax Reform (a taxpayer advocacy group) because so many Members of the General Assembly had signed his "no tax increase" pledge. Relevant to the health industry, some of the recommendations proposed to sunset sales tax exemptions for non profit health care facilities, including hospitals, nursing homes, hospices, free health clinics, and child caring institutions. Federally qualified health centers had already lost their sales tax exemptions in 2010.

Four tax bills with all of the Special Council's recommendations were introduced by the Special Joint Committee to be available for Committee amendments. In the end, this Special Joint Committee sent two bills to the House Rules Committee that contained some recommendations of the Special Council. The Special Joint Committee eliminated the sunset of the nonprofit sales tax exemptions, thus protecting non profit hospitals and nursing homes, and the proposed new tax on consumer services. It also chose to lower the personal income tax, but not the corporate income tax, and endorsed the communications tax proposal. Such a proposal could be made revenue neutral by selectively adopting some of the federal income deductions but not all of them. Data from Georgia State University's Andrew Young School of Public Policy, Fiscal Research Center, did not, however, demonstrate that the several proposed levels of personal income tax reduction were, in fact, revenue neutral for some income levels. Even though the data proved controversial, they resulted in the House leadership pulling the substitute bills from the House calendar. The tax reform discussion has now been postponed at least a year, but it is far from clear whether tax reform can be passed during the 2012 election year.

A few tax proposals did pass under other bills, such as a sales tax exemption on sales of jet fuel, continued sales and use exemption for airplane parts used in the maintenance and repair of certain airplanes, and new tax credits for businesses that promote tourism. Efforts to renew sales tax exemptions for the food banks, the free health clinics, and federally qualified health centers, and Goodwill Industries failed. (These exemptions had already expired in 2010 or were set to expire in June, 2011 and needed to be renewed in order to be reviewed.) The failure of these bills was ironic once the Special Joint

Committee removed the sunset of other nonprofit sales tax exemptions from the substitute bills.

The remaining dominant issue was immigration reform. The issue certainly follows intense national anxiety about illegal immigrants consuming governmental services and the difficulties of the Congress being able to pass a reform law. It generates conflict between this strongly held view in American culture and the needs of some American businesses to use immigrant labor to prosper. Several members of both chambers proposed that Georgia adopt a State immigration reform law resembling the Arizona bill currently in litigation. The discussion was vigorous and resulted in proposals to lower the size of businesses which must use the federal E-Verify program to test legal status, generate new authority to test the legal status of persons being transported by someone committing another crime or traffic violation, create a new crime of harboring illegal immigrants, deputize Georgia law enforcement to enforce the federal law provisions, and tighten the existing State law from several years ago. The bill ultimately passed by a large majority, and Governor Deal signed HB 87.

Like Arizona's bill, it has commenced judicial evaluation, with an initial partial injunction ruling rendered on June 27, 2011. In the recent ruling, Judge Thomas Thrash essentially placed a hold on many of the controversial portions of the legislation, including the police's ability to investigate immigration status of individuals considered as suspects in State or federal crimes and the portion of the law regarding punishment of individuals who knowingly transport or harbor illegal immigrants or otherwise promote them to come to Georgia. Judge Thrash threw out the American Civil Liberties Union's arguments that this new law would violate individuals' constitutional rights to travel and have equal protection. Judge Thrash's ruling also requires employers to utilize the federal E-Verify system. Governor Deal has now criticized the ruling, noting that the federal government is the State's thorniest obstacle in addressing illegal immigration. Thus, the State will appeal Judge Thrash's order on HB 87.

Many other issues were deferred to study commissions. A commission will undertake ideas on criminal justice reform and another will address creation of a State health insurance exchange as required under the federal health reform law, the

"Patient Protection and Affordable Care Act." The criminal justice discussion will include health care services provided in jails and prisons. Yet another commission will review all health insurance mandates in current law and any new ones proposed. The Governor also decided to defer evaluation and rebidding of the Medicaid care management organizations for low income Medicaid eligible women and children and any possible extension of managed care to aged, blind or disabled beneficiaries and to children in foster care to a special consultant appointed this summer. That work will include reacting to any Medicaid expansion under federal health reform and recommendations for changes, if any, are deferred until 2012 with implementation in July, 2013. The funding formula for the quality basic education program for Georgia schools is also being reexamined and can affect what funds are available for health care services to kids in special education. All of these will be hot button issues over the next several years.

The bills that passed and are relevant to the health industry are summarized, by topic, below.

Abolishing or Consolidating Government Agencies

HB 509 – Rep. Hank Huckaby (R-Athens) offered this Bill which would abolish the State Medical Education Board and provide for the Georgia Board for Physician Workforce to take over this board's powers, rights, and duties. The Bill would amend Titles 20, 31, 45, 48, and 49. HB 509 passed both the House and Senate and was signed by Governor Deal on May 12, 2011 as **Act Number 113**. These revisions took effect on July 1, 2011 and have monetary savings attached to them that have been incorporated into the State's budget.

Adoption

SB 172 – Sen. David Shafer (R-Duluth) authored this Bill to amend Chapter 8 of Title 19. This piece of legislation would require a home study by an evaluator prior to the placement of a child into the home of adoptive parents by a third party who is neither a stepparent nor a relative and for such study to recommend placement. "Evaluator" is defined as a "licensed child-placing agency, the department, or a licensed professional with at least two years of adoption related professional experience, including a licensed clinical social worker, licensed master social worker, licensed

marriage and family therapist, or licensed professional counselor; provided, however, that where none of the foregoing evaluators are available, the court may appoint a guardian ad litem or court appointed special advocate to conduct the home study." Also, language clarifying that non-identifying medical information contained in adoption records would be open to certain persons for purposes of providing medical treatment and diagnoses, was added to SB 172, and the Governor signed it into law on May 12, 2011 as **Act Number 189**. It took effect on July 1, 2011.

Assisted Living Facilities

SB 178 – Sen. Johnny Grant (R-Milledgeville) authored this Bill to regulate and license assisted living communities. The revisions are added in Chapter 7 of Title 31. It essentially mirrored the House version and also addressed a definition and duties of a "medication aide." Conforming amendments were also made in Titles 10, 16, 25, 26, 31, 35, 37, 38, 42, 48 and 51. This Bill became a compromise between all the relevant parties including the assisted living entities, the long-term care ombudsman, Georgia Health Care Association, and personal care homes. In this legislation, it requires that "an assisted living community shall not admit or retain an individual who is not ambulatory unless the individual is capable of assisted self-preservation. In the event that the department determines that one or more residents of an assisted living community are not capable of assisted self-preservation due to the condition of the resident, the capabilities of the staff of the assisted living community, the construction of the building in which the assisted living community is housed, or a combination of these factors, the department shall have the authority to consider any of the following actions: (1) An increase in the staffing of the assisted living community to a level that is sufficient to ensure that each resident is capable of assisted self-preservation; (2) A change in the staffing assignments of the assisted living community if such change would ensure that each resident is capable of assisted self-preservation; (3) A change in rooms or the location of residents as necessary to ensure that each resident is capable of assisted self-preservation; (4) The utilization of any specialized equipment that would ensure that each resident is capable of assisted self-preservation. For purposes of this paragraph, specialized equipment shall only include a prosthesis, brace,

cane, crutches, walker, hand rails, and a wheelchair; (5) A cessation in the further admission of individuals who are not ambulatory until such time that the assisted living community has taken actions necessary to ensure that all residents are capable of assisted self-preservation; (6) The transfer or discharge of any resident who is not capable of assisted self-preservation; and (7) Any action set forth in Code section 31-2-11." The Department of Community Health must also keep a registry of these medication aides who are certified by the Department. It passed both the House and the Senate and was signed into law by the Governor on May 4, 2011 as **Act Number 56**. This new level of care took effect on July 1, 2011.

Continuing Care Communities

SB 166 – Sen. Jesse Stone (R-Waynesboro) proposed this Bill to extensively revise the requirements for continuing care providers and facilities in Chapter 45 of Title 33. Among the many changes include several new "definitions" for terms such as "continuing care" or "care" which means "furnishing pursuant to an agreement lodging that is not in a skilled nursing facility as defined in paragraph (34) of Code Section 31-6-2, an intermediate care facility as defined in paragraph (22) of Code Section 31-6-2, or a personal care home as defined in Code Section 31-7-12; food and nursing care, whether such nursing care is provided in the facility or in another setting designated by the agreement for continuing care, to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee." It defines the "entrance fee" and "monthly care fee" in the agreements. The Commissioner of Insurance is granted enforcement powers in O.C.G.A. § 33-45-2 over these types of agreements to be sold. These entities providing continuing care or limited continuing care must obtain a certificate of authority in O.C.G.A. § 33-45-4. On an annual basis before June 1, the provider will be required to file a revised disclosure statement and other information and data which shows its condition as of the last day of the preceding calendar year or fiscal year of the provider and the provider is now required to make such revised disclosure statement available to all the residents of the facility; further, these providers are to revise the disclosure statement at any other time if revision is necessary to prevent an otherwise current disclosure statement from containing a material misstatement of fact or otherwise omitting a

material fact required to be stated therein. It adds specific items to be contained in the disclosure statement in O.C.G.A. § 33-45-10(d) and now requires minimum financial reserves equal to 25 percent of the total operating costs of the facility projected for the 12 month period following the period covered by the most recent audited financial statements (in the disclosure statement) in O.C.G.A. § 33-45-11 (there is a different calculation for a provider or facility which has opened but has not achieved full occupancy). After passing the House and the Senate, SB 166 was signed into law by the Governor on May 11, 2011 as **Act Number 77**. The changes became effective on July 1, 2011.

Dental Services

HB 189 – Rep. Joe Wilkinson (R-Atlanta) offered this amendment to create the "Noncovered Dental Services Act." It provides in O.C.G.A. § 33-24-59.14(b) that no contract or agreement between a dental insurer or network and a dentist may require the dentist to accept an amount for dental care services that are not covered under a dental benefit plan. The Bill passed both the House and Senate and was signed into law by Governor Deal on May 12, 2011 as **Act Number 198**. The changes took effect on July 1, 2011.

Education

HB 227 – Rep. Valerie Clark (R-Lawrenceville) authored this Bill to revise O.C.G.A. § 20-2-776(g) pertaining to auto-injectable epinephrine medications carried by students. It specifically adds language so as not to prohibit a school "from receiving and storing prescription auto-injectable epinephrine onsite on behalf of a student who is not able to self-administer the medication because of age or any other reason if the parent or guardian provides: (1) A written statement from a physician licensed under Chapter 34 of Title 43 detailing the name of the medication, method, amount, and time schedules by which the medication is to be taken; and (2) A written statement by the parent or guardian providing a release for the school nurse or other designated school personnel to consult with the physician regarding any questions that may arise with regard to the medication, and releasing the school system and its employees and agents from civil liability. The written statements specified in this subsection shall be provided at least annually and more frequently if the medication, dosage, frequency of administration, or reason for administration changes." New language

is also added in O.C.G.A. § 20-2-776.1 to require local school boards to disseminate information to schools on recognizing anaphylactic shock and providing school personnel an immunity from civil liability for those who administer or choose not to administer these "Epi Pens;" however, the immunity from civil liability will not apply if there is willful or wanton misconduct. This Bill became **Act Number 88** on May 11, 2011. This initiative took effect on July 1, 2011.

SB 120 – Sen. Butch Miller (R-Gainesville) authored this Bill, which seeks to amend O.C.G.A. § 20-2-142(b) and O.C.G.A. § 40-5-25(f). It would amend Georgia's current law requiring that the State Board of Education and the Board of Driver Services to jointly establish an alcohol and drug course for the purpose of informing the young people in the state of the dangers involved in consuming alcohol or certain drugs in connection with the operation of a motor vehicle. The Bill would require that a parent or guardian would participate in the alcohol and drug course required for obtaining a driver's license for a person under 18 years of age. The Bill passed out of the Senate Public Safety Committee, but it did not make it through the Senate on Crossover Day. See HB 269 which was passed and signed as **Act Number 89** on May 11, 2011 as it incorporated such language.

Emergency Services; 9-1-1 Services

HB 256 – Rep. Wendell Willard (R-Sandy Springs) proposed this initiative to regulate 9-1-1 charges on prepaid wireless services. It adds at O.C.G.A. § 46-5-121(e) the language, "General Assembly further finds that the collection methodology for prepaid wireless telecommunications service should effectively capture 9-1-1 charges from prepaid users. It is the intent of the General Assembly to move the collection of existing 9-1-1 charges on prepaid wireless service to the retail point of sale." A new Code Section is created at O.C.G.A. § 46-5-134.2, addressing the particulars of the fee calculation and collection for these prepaid 9-1-1 wireless charges. It was passed and became **Act Number 96** on May 11, 2011 and took effect on that date.

HB 280 – Rep. Ben Harbin (R-Evans) introduced this legislation, which amends the "Georgia Emergency Telephone Number 9-1-1 Service Act of 1977." Another one of the amendments is an amendment to O.C.G.A. § 46-5-134(f), relating to the Emergency Telephone System Fund and what

it may pay for, adding that this Fund can be used for paying salaries and "employee benefits incurred by the local government for employees hired by the local government solely for the operation and maintenance of the emergency 9-1-1 system." It passed and was signed on May 5, 2011 as **Act Number 57**. The Act took effect on July 1, 2011.

HB 339 – Rep. Andy Welch (R- McDonough) authored this initiative revising O.C.G.A. § 38-3-51 and the courts to which a challenge of a quarantine or vaccination order may be brought and the manner of appealing orders concerning such challenges. Now, such challenge must be dealt with by the superior court in the county where the individual or a member of the class resides or in Fulton County. It adds at O.C.G.A. § 38-3-51(i)(2)(E): " The department or any party may immediately appeal any order to the Supreme Court pursuant to paragraph (7) of subsection (a) of Code Section 5-6-34. The Supreme Court, or to any available Justice thereof in the event that circumstances render a full court unavailable, shall consider the appeal on an expedited basis and may suspend any time requirements for the parties to file briefs. In the event no Justice is available, then a panel of the Court of Appeals, or any Judge thereof in the event that circumstances render a panel unavailable, shall consider the appeal on an expedited basis and may suspend any time requirements for the parties to file briefs." Additionally, in O.C.G.A. § 38-3-61(b), it now reads: "An order declaring the existence of a judicial emergency shall be limited to an initial duration of not more than 30 days; provided, however, that the order may be modified or extended for no more than two periods not exceeding 30 days each unless a public health emergency exists as set forth in Code Section 38-3-51, in which case the Chief Justice of the Supreme Court of Georgia may extend the emergency order for so long as such emergency exists, as declared by the Governor. Any modification or extension of the initial order shall require information regarding the same matters set forth in subsection (a) of this Code section for the issuance of the initial order." This legislation passed and Governor Deal signed this legislation on May 13, 2011 as **Act Number 242**; it took effect on July 1, 2011.

HB 365 – Rep. Ben Harbin (R-Evans) proposed this Bill in O.C.G.A. § 33-1-19, which would require that certain membership subscription agreements for prepaid air ambulance service not constitute a contract of insurance. The initiative did not make

it out of the House Insurance Committee. However, this language was added into HB 248, which passed and was signed into law. See HB 248.

HB 486 – Rep. Greg Morris (R-Vidalia) introduced this piece of legislation to amend O.C.G.A. § 33-1-19. It would require that certain membership subscription agreements for prepaid air ambulance service not constitute a contract of insurance. The Bill did not navigate its way through the House Insurance Committee. See HB 248 as it incorporated the language and was signed as **Act Number 86** on May 11, 2011; the provisions in Act Number 86 took effect on July 1, 2011.

SB 156 – Sen. Rick Jeffares (R-Locust Grove) passed this legislation which in part amends O.C.G.A. § 46-5-134(m)(1), relating to billing of subscribers, liability of subscriber for service charge, taxes on service, establishment of Emergency Telephone System Fund, records, and use of federal, state, municipal, or private funds, as follows: "Any local government collecting or expending any 9-1-1 charges or wireless enhanced 9-1-1 charges in any fiscal year beginning on or after July 1, 2005, shall document the amount of funds collected and expended from such charges. Any local government collecting or expending 9-1-1 funds shall certify in their audit, as required under Code Section 36-81-7, that 9-1-1 funds were expended in compliance with the expenditure requirements of this Code section." Governor Deal signed this Bill into law as **Act Number 187** on May 12, 2011; it took effect on that date.

Forensic Medical Issues

SB 80 – Sen. Josh McKoon (R-Columbus) passed this legislation enacting the "Johnia Berry Act." One of the major provisions of the Bill is in O.C.G.A. § 17-5-56(b) requiring that "evidence in all felony cases that contains biological material, including, but not limited to, stains, fluids, or hair samples that relate to the identity of the perpetrator of the crime shall be maintained for the period of time that the crime remains unsolved or until the sentence in the case is completed, whichever occurs last." Additionally, at O.C.G.A. § 35-3-160(b) it now requires that any person who is convicted of a felony offense and held in a detention facility or placed on probation shall at the time of entering the detention facility or being

placed on probation have a sample of his or her blood, an oral swab, or a sample obtained from a noninvasive procedure taken for DNA (deoxyribonucleic acid) analysis to determine identification characteristics specific to the person. Governor Deal signed this Bill as **Act Number 67** on May 11, 2011, and it became effective upon signature.

HB 503 – Rep. Amy Carter (R-Valdosta) introduced this initiative, which provides funding for forensic medical examinations of victims involved in certain sexual offenses. The Bill would define a "forensic medical examination" and would require the Georgia Crime Victims Emergency Fund, as provided for in Chapter 15 of Title 17, would be financially responsible for the cost of the medical examination for an amount not to exceed \$1,000. The Bill passed the House and Senate and was signed by the Governor on May 3, 2011 as **Act Number 53**. The changes took effect on July 1, 2011.

Georgia Health Exchange Authority and Health Reform

HB 476 – Rep. Richard Smith (R-Columbus) authored this piece of legislation to establish the "Georgia Health Exchange Authority" in Chapter 65 of Title 33. The Bill proposed to create the "GHEA" as a body corporate and politic, an instrumentality of the state, and a public corporation. It would be able to contract and be contracted with and bring and defend actions. This authority would be governed by a board of directors composed of nine members who are residents of the State of Georgia. It further proposed the establishment of a Small Business Health Options Program ("SHOP") Exchange to assist qualified small employers in Georgia in facilitating the enrollment of their employees in qualified health plans offered in the small group market. HB 476 did not make it to the House Floor because of efforts to thwart its passage by the Tea Party, and therefore, it failed. The language of the Bill was added to SB 177 as it moved through the process, but no agreement was reached on SB 177 on the last day of the Session. Thus, SB 177 also did not pass.

Healthcare

HB 303 – Rep. Sharon Cooper (R-Marietta) proposed this Bill addressing delegation of authority to physician's assistants ("PA") and

advanced practice registered nurses in Chapter 34 of Title 43. It clarifies their authority to request, receive and sign for professional samples and to distribute such samples to patients. Further, it permits these individuals to "sign, certify, and endorse all documents relating to health care provided to a patient within his or her scope of authorized practice, including, but not limited to, documents relating to physical examination forms of all state agencies and verification and evaluation forms of the Department of Human Services, the State Board of Education, local boards of education, the Department of Community Health, and the Department of Corrections." However, it does *not* permit either the PA or advanced practice registered nurse to sign death certificates or assign a percentage of a disability rating. Finally, it amends current requirements as to when a physician must physically see a patient when that patient has been receiving medical care from a PA; it removes the 12-month requirement and will now require that the physician may see the patient as "appropriate to the nature of the practice and the acuity of the patient's medical issue, as determined by the supervising physician." This legislation passed and was signed as **Act Number 110** on May 11, 2011. It took effect on July 1, 2011.

HB 461 – Rep. Rick Jasperse (R-Jasper) offered this creation of a new Chapter 48 to Title 31 in order to adopt the "Health Care Compact." The Bill states that the federal government has enacted many laws that have preempted state laws with respect to health care, and placed increasing strain on state budgets, impairing other responsibilities. It is a reaction to the federal health care reforms. After clearing the House, it passed the Senate on the last day of the legislative Session. Governor Deal signed HB 461 into law on April 20, 2011 as **Act Number 10**; it took effect on July 1, 2011.

Health Insurance

HB 47 – Rep. Matt Ramsey (R-Peachtree City) proposed this initiative, which would amend Chapter 29A of Title 33. This was known as the "cross state" selling of insurance. The Bill authorizes insurance companies to offer individual accident and sickness insurance policies in Georgia that have been approved for issuance in other states. Rules and regulations will be required to be developed before being fully implemented. It was passed by the House and Senate and was signed by Governor Deal as **Act Number 249** on May 13, 2011. It took effect on July 1, 2011.

HB 167 – Rep. Steve Davis (R-McDonough) authored these amendments to Title 33, which would be known as the "Insurance Delivery Enhancement Act of 2011." These changes are amendments to Georgia's "prompt pay" insurance laws. This initiative was vetoed by Governor Perdue after passing in 2010. However, this 2011 version brings third-party administrators into Georgia's prompt pay laws. The legislation also amends requirements for payment of claims, moving the time within which the insurer must respond for an electronically submitted claim of 15 days and 30 days to respond to a claim submitted on paper once all documentation required to process the claim is received. Interest on claims not paid is reduced from 18 percent per annum to 12 percent per annum. Further, an insurer will be subject to penalties to be assessed by the Commissioner of Insurance for not paying 95 percent of its claims in a timely manner. The legislation also includes changes to "association" forms of insurance; under current law, it requires 25 persons to be an association and this legislation lowers that requirement to ten persons. While there were numerous concerns presented relating to this initiative, including its effect on ERISA, the Bill passed this year. Governor Deal signed the legislation into law on May 12, 2011 as **Act Number 196**. The amendments to the law relating to timely payment of benefits will take effect on January 1, 2013, and all other portions of the legislation took effect on July 1, 2011.

HB 248 – Rep. Jay Neal (R-LaFayette) submitted this piece of legislation known as the "Health Care Sharing Ministries Freedom to Share Act." It adds at O.C.G.A. § 33-1-19 that a health care sharing ministry, which enters into a health care cost sharing arrangement with its participants, would not be considered an insurance company, health maintenance organization, or health benefit plan of any class, kind, or character. Further, it clarifies at O.C.G.A. § 33-1-20(b) that "the solicitation of membership subscriptions, the acceptance of applications for membership subscriptions, the charging of membership fees, and the furnishing of prepaid or discounted air ambulance service subscription members by a membership provider shall not constitute the writing of insurance." [This language regarding air ambulance service subscriptions also was introduced as standalone pieces of legislation. There were two such bills, HB 365 and HB 486; neither passed.] Further, such "subscription" would not constitute as a contract of

insurance. HB 248 passed both the House and Senate and was signed by the Governor on May 11, 2011 as **Act Number 86**. The provisions took effect on July 1, 2011.

HB 275 – Rep. Mike Cheokas (R-Americus) proposed this initiative to amend Chapter 39 of Title 31 related to cardiopulmonary resuscitation. The Bill clarifies when health care providers are authorized to effectuate an order not to resuscitate. In O.C.G.A. § 31-39-6(a), it now reads that, "Any written order issued by the attending physician using the term 'do not resuscitate,' 'DNR,' 'order not to resuscitate,' 'no code,' or substantially similar language in the patient's chart shall constitute a legally sufficient order and shall authorize a physician, health care professional, nurse, physician assistant, caregiver, or emergency medical technician to withhold or withdraw cardiopulmonary resuscitation." Previously, a nurse, physician's assistant or caregiver could not withhold or withdraw cardiopulmonary resuscitation. The Bill passed both the House and the Senate and was signed into law by Governor Deal on May 11, 2011 as **Act Number 92**. The changes took effect on July 1, 2011.

HB 303 - Rep. Sharon Cooper (R-Marietta) proposed this Bill addressing delegation of authority to physician's assistants ("PA") and advanced practice registered nurses in Chapter 34 of Title 43. It clarifies their authority to request, receive and sign for professional samples and to distribute such samples to patients. Further, it permits PA's and advanced practice registered nurses to "sign, certify, and endorse all documents relating to health care provided to a patient within his or her scope of authorized practice, including, but not limited to, documents relating to physical examination forms of all state agencies and verification and evaluation forms of the Department of Human Services, the State Board of Education, local boards of education, the Department of Community Health, and the Department of Corrections." However, it does not permit either the PA or advanced practice registered nurse to sign death certificates or assign a percentage of a disability rating. Finally, it amends current requirements as to when a physician must physically see a patient when that patient has been receiving medical care from a PA; it removes the 12-month requirement and will now require that the physician may see the patient as "appropriate to the nature of the practice and the acuity of the patient's medical issue, as determined

by the supervising physician." This legislation passed, and Governor Deal signed it into law on May 12, 2011 as **Act Number 110**. This Act took effect on July 1, 2011.

SB 17 - Sen. Tim Golden (R-Valdosta) authored this initiative mirroring a similar proposal passed by the State of Virginia. The Bill establishes the "Special Advisory Commission on Mandated Health Insurance Benefits" by creating a new Code Section at O.C.G.A. § 33-1-19. This twenty member Commission becomes effective February 1, 2012 with its first meeting taking place no later than March 1, 2012. Duties of this Commission are as follows:

- (1) Develop and maintain, with the Department of Insurance, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers, and other data as may be appropriate;
- (2) Advise and assist the Department of Insurance on matters relating to mandated insurance benefits and provider regulations;
- (3) Prescribe the format, content, and timing of information to be submitted to the advisory commission in its assessment of proposed and existing mandated benefits and providers. Such format, content, and timing requirements shall be binding upon all parties submitting information to the advisory commission in its assessment of proposed and existing mandated benefits and providers;
- (4) Provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the General Assembly;
- (5) Provide additional information and recommendations, relating to any system of mandated health insurance benefits and providers, to the Governor and the General Assembly, upon request; and
- (6) Report annually on its activities to the joint standing committees of the General Assembly having jurisdiction over insurance by December 1 of each year.

It passed both the Senate and House and was signed by Governor Deal on May 11, 2011 as **Act Number 78**. This law took effect on July 1, 2011.

Hemophilia Advisory Board

HB 378 – Rep. Sean Jerguson (R-Woodstock) proposed this Bill at the request of Baxter Pharmaceuticals to create an advisory board relating to individuals with hemophilia or bleeding disorders in O.C.G.A. § 31-1-112. This Board would be attached to the Department of Community Health, and its members would "review and make recommendations to the Commissioner of Community Health with regard to issues that affect the health and wellness of persons living with hemophilia and other bleeding disorders." This legislation failed to move from the House Rules Committee, but the language creating this Hemophilia Advisory Board was attached to HB 214 which passed and is discussed further in the Report under "Public Health." See HB 214 which was signed into law on May 13, 2011 as **Act Number 244** and took effect on July 1, 2011.

Insurance

HB 477 – Rep. Jason Shaw (R-Lakeland) introduced this initiative to allow for the transition from an annual renewal to a biennial renewal of licenses of insurance agents, agencies, subagents, counselors, and adjusters. This Bill proposed to amend Chapters 8 and 23 of Title 33. It passed the House but never made it to the Senate floor. Thus, HB 477 failed. The Senate's version of this licensing bill, SB 251, passed and was signed into law as **Act Number 220** on May 12, 2011. Act Number 220 took effect on the date of signature. See SB 251.

SB 278 – Sen. Greg Goggans (R-Douglas) proposed this year's Life Settlement law revision which was introduced on April 11, 2011. Among the changes include creation of a new Code Section at O.C.G.A. § 33-59-11, which would require an insurance company to "notify the owner of an individual life insurance policy when the insured person under such policy is 60 years of age or older, or is known to be terminally ill or chronically ill, that there may be alternative transactions available to that owner: (1) When a life insurance company receives from such owner a request to surrender, in whole or in part, an individual policy; (2) When a life insurance company receives from such owner a request to receive an accelerated death benefit under an individual policy; (3) When a life insurance company sends to such owner all notices of lapse of an individual policy; or (4) At any other

time that the Commissioner may require by rule." It also adds additional prohibited practices by an insurer in O.C.G.A. § 33-59-14 (such as making any false statements regarding the business of life settlements). Thus, the legislation remained in the Senate Insurance and Labor Committee.

Juveniles and Juvenile Justice

HB 185 – Rep. Tom Weldon (R-Ringgold) authored this idea adding language in Titles 16 and 49, at the request of several child care providers, to create the "Runaway Youth Safety Act." After having a number of hearings before the House Judiciary (Non-Civil) Committee, the Bill cleared that Committee but remained in the House Rules Committee. It proposed to permit a registered services provider the ability to house a child for up to 72 hours of the child's receiving of services before requiring that the parents or the Division of Family and Children's Services be notified of that child's location. The language was incorporated into SB 94 which passed and became **Act Number 115** on May 11, 2011; its provisions became effective on July 1, 2011. See SB 94.

SB 94 – Sen. Bill Heath (R-Bremen) authored this legislation relating to guns and their definitions as it cleared the Senate. However, in the House Judiciary Non-Civil Committee, the Bill was stripped and it became the "Runaway Youth Safety Act." The amendments were made in Titles 16 and 49 to permit a "service provider," which is "an entity that is registered with the Department of Human Services pursuant to Article 7 of Chapter 5 of Title 49 or a child welfare agency as defined in Code Section 49-5-12 or an agent or employee acting on behalf of such entity or child welfare agency," the ability to house a runaway youth for up to 72 hours without being subject to interference of child custody. The service provider would be required to notify the youth's parents, guardian or legal custodian within 72 hours of the child accepting services from that service provider. There are certain exceptions to this notification (such as if the service provider has reasonable cause to believe the child is the victim of abuse or neglect). This legislation passed as it was amended, and Governor Deal signed the legislation into law as **Act Number 115** on May 11, 2011. The Act took effect on July 1, 2011.

Lobbyists

HB 232 – Rep. Edward Lindsey (R-Atlanta) authored this amendment to O.C.G.A. § 21-5-70, with a new definition for the term, "lobbyist," affecting the contingency compensation of vendor salespersons. The Bill would not require bona fide salespersons to register as lobbyists or otherwise be considered to be lobbyists. It outlines a "test" based on the amount of time expended by an employee in certain business activities before that person must be required to register as a lobbyist, basically more than 10% of an employee's time. The legislation also addressed some report filing requirements, including adding a three-day grace periods for lobbyists' reporting requirements in O.C.G.A. § 21-5-73(i). The Bill was passed and signed into law by Governor Deal on March 15, 2011 as **Act Number 4**. It took effect upon signature.

Medicaid

SB 63 – Sen. John Albers (R-Roswell) introduced this Bill on behalf of essentially one manufacturer of biometric software, Exodus, located in Blackshear, Georgia. It would create a new form of tracking Medicaid and PeachCare for Kids fraud by using smart cards and fingerprint data to be obtained from all providers of Medicaid and/or PeachCare benefits at the "point of transaction" (receiving services or treatment). As proposed, this fraud program would initially roll out in a pilot initiative, established by the Department of Community Health, for no more than six months. It would then be permitted to be implemented statewide, using one or more third-party vendors with the Department picking up the costs of the associated equipment. Changes were made to the Bill from its inception. The Bill would create this program in O.C.G.A. § 49-4-200 et seq. A fiscal note proposed its costs for the six month pilot to be approximately \$600,000 or for a statewide roll out at around \$23 million. This Bill was backed by Sen. Tommie Williams (R-Lyons). However, it did not make it out of the House Health and Human Services Committee.

HB 229 – Rep. Sharon Cooper (R-Marietta) offered this Bill, which was heard in the House Judiciary Committee and favorably reported out. However, the Bill stalled in the House Rules Committee. It proposed to amend O.C.G.A. § 49-4-153(b) pertaining to Medicaid administrative hearings and appeals so that the Department of Community Health, within ten business days of receiving the request for hearing from the applicant or recipient,

would be required to transmit a copy of the request to the Office of State Administrative Hearings. Further, it proposed that the decision of the administrative law judge would be the final administrative decision of the Commissioner. The initiative also offered a new Code Section at O.C.G.A. § 49-4-158 to require that the Department would annually submit a report in January to the Senate and House Judiciary and Health and Human Services Committees detailing the Department's compliance/noncompliance with the required time frames, including those outlined in O.C.G.A. § 49-4-146 and O.C.G.A. § 49-4-153.

HB 489 – Rep. Sharon Cooper (R-Marietta) proposed this Bill adding a new Code Section at O.C.G.A. § 49-4-151.1 addressing Medicaid audits. The Bill was brought at the request of the Georgia Hospital Association and proposed to prohibit contingency fee contracts with recovery audit contractors in determining overpayment or underpayment of Medicaid payments. It further proposed to require the State to prepare and submit a Medicaid State plan amendment for a waiver from the federal government for these purposes. The Bill successfully passed, but it was vetoed by Governor Deal on May 13, 2011 as **Veto Number 8**. In part, Governor Deal's veto message indicated that the "implementation of HB 489 would result in Georgia's Medicaid program being out of compliance with federal law, which would put at risk billions of dollars in federal medical assistance funding to the State because federal funds are not available to State Medicaid programs that are out of compliance with the federal Medicaid State plan requirements, such as the ones found in 42 U.S.C. 1396a(a)(42)."

Medical Identity Fraud

SB 19 – Sen. Judson Hill (R-Marietta) proposed establishing a new crime of "medical identity fraud" in O.C.G.A. § 16-9-120. It defines "health care records" as "records however maintained and in whatever form regarding an individual's health, including, but not limited to, doctor's and nurse's examinations and other notes, examination notes of other medical professionals, hospital records, rehabilitation facility records, nursing home records, assisted living facility records, results of medical tests, X-rays, CT scans, MRI scans, vision examinations, pharmacy records, prescriptions, hospital charts, surgical records, mental health treatments and counseling, dental records, and physical therapy notes and evaluations." However,

this Bill was completely gutted and language from HB 164 about coin operated amusement machines was inserted. SB 19 passed both chambers with the new language inserted. *However*, Governor Deal vetoed this Bill as **Veto Number 1** on May 13, 2011 because he did not "believe SB 19 provides sufficient clarity or enforcement powers to shut down internet cafes." Further, he also stated that "the modifications to the current Class A and Class B classifications of coin operated machines could lead to unintended consequences."

Medical Malpractice

SB 149 - Sen. Bill Ligon (R-Brunswick) authored this Bill proposing to create a new Article 10 in Chapter 4 of Title 49 beginning at O.C.G.A. § 49-4-195 et seq. to be known as the "Georgia Medicaid Access Act." It specifically provides in O.C.G.A. § 49-4-195.2 that "actions against a provider of medical assistance shall be covered under this article for the provision of medical or remedial care or service to a recipient of medical assistance regardless of whether such recipient of medical assistance is later to be found ineligible." It would establish in O.C.G.A. § 49-4-195.3 that all the legal requirements for such a medical malpractice claim will be the same as for those for a medical malpractice claim in O.C.G.A. § 9-3-70 unless otherwise specified. The filing of the proposed complaint would toll the applicable statute of limitations to and include a period of 90 days following the receipt of the opinion of the medical review panel by the plaintiff in O.C.G.A. § 49-4-195.4(b). This Bill remained in the Senate Judiciary Committee.

Mental Health

HB 324 – Rep. Jay Neal (R-LaFayette) introduced this initiative to update provisions relating to developmentally disabled persons obtaining services from the Department of Behavioral Health and Developmental Disabilities. The Bill would allow for hearings by administrative law judges and eliminate hearing examiners within Chapter 4 of Title 37. It also adds in O.C.G.A. § 37-4-5(b), relating to validity of hospitalization orders entered before September 1, 1978, "no hospitalization of a person with developmental disabilities which was lawful before July 1, 2011, shall be deemed unlawful because of the repeal of former Code sections under Article 2 of this chapter." It passed both the House and Senate and was signed into law by Governor Deal on May 11,

2011 as **Act Number 84**. It took effect on July 1, 2011.

HB 343 – Rep. Sharon Cooper (R-Marietta) authored this Bill at the request of the Department of Behavioral Health and Developmental Disabilities to be responsive to the Department of Justice's settlement with the State. It provides for crisis stabilization units (also referred to as "CSUs") for providing psychiatric stabilization and detoxification services in Title 37. These units would be used to serve individuals on a short-term (24-hour) basis with residential services. The Department of Behavioral Health and Developmental Disabilities is charged with licensing these services. The Senate Health and Human Services Committee added language regarding immunity of hospitals in providing care to persons when they meet the applicable standard of care for persons with mental illness in O.C.G.A. § 37-3-4 and O.C.G.A. § 37-3-163. This Bill passed, and it was signed into law by the Governor on May 11, 2011 as **Act Number 85**. These changes took effect on July 1, 2011.

HB 421 – Rep. Andy Welch (R-McDonough) dropped this Bill, which would amend Title 17 by changing the proceedings upon a plea of mental incompetency to stand trial. It adds a new Code Section at O.C.G.A. § 17-7-129 which states:

(a) When information becomes known to the court sufficient to raise a bona fide doubt regarding the accused's mental competency to stand trial, the court has a duty, *sua sponte*, to inquire into the accused's mental competency to stand trial. The court may order the Department of Behavioral Health and Developmental Disabilities to conduct an evaluation of the accused's competency. If the court determines that it is necessary to have a trial on the issue of competency, the court shall follow the procedures set forth in Code Section 17-7-130. The court's order shall set forth those facts which give rise to its bona fide doubt as to the accused's mental competency to stand trial. The evaluation of the Department of Behavioral Health and Developmental Disabilities shall be submitted to the court, and the court shall submit such evaluation to the attorney for the accused or, if pro se, to the accused, but otherwise, the report shall remain under seal.

(b) If the court orders a competency evaluation and the accused serves notice of a special plea of mental incompetency to stand trial or raises the issue of insanity, the court shall release the competency evaluation to the prosecuting attorney. Such evaluation shall not be released to any other person absent a court order.

It permits a bench trial or a special jury trial for such proceedings. The Bill passed both the House and Senate and was signed by Governor Deal on May 11, 2011 as **Act Number 91**; these provisions took effect on July 1, 2011.

SB 39 – Sen. Johnny Grant (R-Milledgeville) proposed this amendment to Title 15 which would create mental health court divisions and establish guidelines for planning groups and the assignment of cases specifically at O.C.G.A. § 15-1-16. In order to meet the eligibility criteria, the defendant must suffer from a mental illness, developmental disability, or a co-occurring mental illness and substance abuse disorder. The Judicial Council of Georgia will develop standards for these courts; the courts will have the authority to accept grants and donations and other proceeds from outside sources for the purpose of supporting these new court divisions. The Bill passed both the House and the Senate and was signed into law by Governor Deal on May 4, 2011 in Milledgeville as **Act Number 55**. This law went into effect on July 1, 2011.

Minimum Wage

HB 97 – Rep. Tyrone Brooks (D-Atlanta) proposed this Bill, which would amend O.C.G.A. § 34-4-3(b) and increase the minimum wage paid by Georgia employers. Specifically, this new revision would increase the wage in Georgia from \$5.15 per hour to \$6.20 per hour and proposed annual minimum wage increases in order to keep pace with inflation. Currently, Chapter 4 of Title 34 does not apply to employers with \$40,000 or less annual sales; this proposal would raise that threshold to \$50,000 or less annual sales before the wage laws would be effective. The Bill did not move out of the House Industrial Relations Committee.

Motor Vehicles

SB 88 – Sen. Jeff Mullis (R-Chickamauga) introduced this Bill amending O.C.G.A. § 40-8-76 and O.C.G.A. §40-8-76.1 to increase the age requirements for use of child restraint systems and

safety belts from six years of age to eight years of age in a passenger vehicle. The requirement will be based also on the weight of the child. The legislation passed and Governor Deal signed this legislation as **Act Number 62** on May 9, 2011. This Act became effective on July 1, 2011.

Nurses and Nursing

HB 99 – Rep. Valerie Clark (R-Lawrenceville) proposed this Bill to require fingerprint record checks for applicants for licensure as a licensed practical nurse be conducted by the Georgia Crime Information Center and the Federal Board of Investigation as determined by the board. The Bill amends Chapter 26 of Title 43 and was passed by the Senate on March 29, 2011. HB 99 was signed by Governor Deal on May 11, 2011, becoming **Act Number 107**. This Act took effect on July 1, 2011.

HB 426 – Rep. Sean Jerguson (R-Holly Springs) submitted this Bill, which would revise a definition in the "Georgia Registered Professional Nurse Practice Act" in O.C.G.A. § 43-26-3. In regards to what is considered to be an approved nursing education program, it would allow a nonprofit postsecondary institution of higher learning that is a four-year institution that is not accredited but whose curriculum meets the necessary criteria. HB 426 was specifically designed to suit the needs of Pensacola Christian College. The Bill did not leave the House Health and Human Services Committee but its Senate counterpart, SB 100, passed both chambers. See SB 100.

HB 470 – Rep. Sharon Cooper (R-Marietta) proposed this amendment to O.C.G.A. § 43-26-7, which would revise requirements for preceptorships for certain applicants as well as revise requirements related to nontraditional nursing education programs. This Bill has many similarities to SB 187 from Sen. Josh McKoon (R-Columbus). HB 470 did not make it out of Senate Rules Committee, but language from the Bill was inserted into SB 100 which passed. See SB 100.

SB 67 – Sen. Buddy Carter (R-Pooler) offered this initiative which would prohibit the use of the title "nurse" unless licensed as a registered professional nurse or a licensed practical nurse in Chapter 26 of Title 43. The Bill passed the Senate but did not make it out of the House Health and Human Services Committee. The language was included in SB 100, which was passed. See SB 100.

SB 100 – Sen. Mitch Seabaugh (R-Sharpsburg) proposed this Bill originally to address the issue of Pensacola Christian College and its nursing graduates' ability to sit for licensure in Georgia. The Bill was amended when it reached the House in the House Health and Human Services Committee where that Committee added language in O.C.G.A. § 43-26-6(c) and O.C.G.A. § 43-26-33(d) clarifying when an individual could use the title of "nurse." When the Bill reached the House Floor, it arrived in yet another version, adding the language to address issues pertaining to the clinical training for online Excelsior nursing school graduates (or nontraditional nursing education programs) who have been precluded from sitting for licensure in Georgia. The language added is in O.C.G.A. § 43-26-7(b) providing credit for prior training if those graduates have prior experience (under certain conditions) as licensed practical nurses or paramedics. Other Bills on these issues involved HB 470 (by Rep. Sharon Cooper, which was reported out of the Senate Health and Human Services Committee) and SB 187 (by Sen. Josh McKoon which was killed in the House Health and Human Services Committee with a do not favorably report the Bill out of Committee). SB 100 passed and Governor Deal signed the legislation into law as **Act Number 247** on May 13, 2011; it took effect upon signature of the Governor.

SB 183 – Sen. Greg Goggans (R-Douglas) proposed this amendment to O.C.G.A. § 20-2-771.2 to allow school nurse health programs to consult with offsite health care professionals through appropriate protocols and contracts (telemedicine). The Bill passed the Senate but was not given an opportunity to be voted on in the House.

SB 187 – Sen. Josh McKoon (R-Columbus) proposed this Bill to amend Title 43 which would be known as the "Georgia Registered Professional Nurse Practice Act." The Bill would revise the nursing education program requirements for licensure as a registered nurse. It would also change certain provisions relating to the requirements for registered professional nurses in nontraditional nursing education programs. The House Health and Human Services Committee unfavorably reported on SB 187 but the language of the Bill found its way into SB 100. Therefore, the essence of SB 187 passed, however, in the body of SB 100. The Governor has signed SB 100 into law. See SB 100.

Pharmaceutical and Pharmacy

HB 227 – Rep. Josh Clark (R-Buford) proposed this initiative permitting schools to stockpile "Epi" pens for children with allergic reactions. This Bill was written into O.C.G.A. § 20-2-776 et seq. It provides that local boards of education can develop policies for school personnel to administer the auto-injectable medication for students who are experiencing anaphylactic adverse reaction and provides immunity from liability for teachers and other school personnel who use or choose not to use the epinephrine auto-injectable. The proposal cleared the Senate Education and Youth Committee on March 30, 2011 as it passed the Senate easily. The Bill was signed by Governor Deal on May 11, 2011 as **Act Number 88**. It took effect on July 1, 2011.

HB 457 – Rep. Ron Stephens (R-Savannah) proposed this Bill in Chapter 13 of Title 16 and Chapter 4 of Title 26 to regulate and license remote automated medication systems for institutions without onsite pharmacies. The Bill was introduced specifically for the nursing home industry, including UHS-Pruitt Home, and at the request of a manufacturer of these automated medication systems. The Senate Health and Human Services Committee amended the Bill, narrowing the definition of the term "institution" which is a skilled nursing facility or hospice as licensed in Chapter 7 of Title 31. The Senate Health and Human Services Committee added two other amendments: 1) to extend the date of the drug-free commercial zones to March 28, 2011 which have been adopted by municipal or county ordinance in O.C.G.A. § 16-13-32.6(f) and 2) to amend the definition of "food service establishment" in O.C.G.A. § 26-2-370(2) clarifying such will not include outdoor or indoor (other than school cafeteria food service) public school functions. HB 457 passed both the House and the Senate and was signed by Governor Deal on May 11, 2011 as **Act Number 75**. These new systems and other changes made in this Act took effect on that date.

HB 469 – Rep. Tim Bearden (R-Villa Rica) proposed this legislation in Chapter 4 of Title 26 requiring all hard copy prescriptions to be on "security paper." The Bill defines "security paper" in O.C.G.A. § 26-4-5(38.5) as a "prescription pad or paper that has been approved by the board for use and contains the following characteristics: (A) One or more industry recognized features designed to

prevent unauthorized copying of a completed or blank prescription form; (B) One or more industry recognized features designed to prevent the erasure or modification of information written on the prescription form by the practitioner; and (C) One or more industry recognized features designed to prevent the use of counterfeit prescription forms. Where security paper is in the form of a prescription pad, each pad shall bear an identifying lot number, and each piece of paper in the pad shall be numbered sequentially beginning with the number one." It also limits the numbers of prescription units to be dispensed under one prescription for Schedules II-IV. This Bill remained in the House Health and Human Services Committee. This language was added in SB 36, which was passed and signed as **Act Number 229** on May 13, 2011. The provisions in the Bill took effect on July 1, 2011. See SB 36.

SB 36 – Sen. Buddy Carter (R-Pooler) authored this Bill establishing an electronic prescription drug monitoring program for Schedule II, III, IV, and V controlled substances in Chapter 13 of Title 16. This program will be overseen by the Georgia Drugs and Narcotics Agency which would be funded by the General Assembly, subject to appropriations, or otherwise obtaining funds. Each dispenser of these controlled substances will be required to submit to the Agency on at least a weekly basis, and no later than ten days from the date the prescription is dispensed, certain information (such as name of patient, prescriber, DEA permit number, date of prescription, method of payment, etc.). A dispenser is permitted a process to be waived from compliance with this reporting. An Electronic Database Review Advisory Committee is also established to provide guidance to the Agency. It further adds requirements for wholesale distributors of these controlled substances. Fines and penalties are established for noncompliance with the provisions. In the House, language was taken from Rep. Tim Bearden's Bill, HB 469, which amends O.C.G.A. § 26-4-80.1, concerning the requirement that all hard copy prescriptions are to be on "security paper." Further, it added language from SB 36 where it establishes limits of 60 units to be dispensed by a pharmacist for any Schedule II-V drugs on any prescription drug order. SB 36 passed the House and Senate and was signed by Governor Deal as **Act Number 229** on May 13, 2011. It took effect on July 1, 2011.

SB 81 – Sen. Buddy Carter (R-Pooler) authored this set of changes so as to require mental and physical examinations of licensees or applicants for the practice of pharmacy and for the applicants for registration as pharmacy technicians. This governance of these examinations would be overseen by the Georgia Board of Pharmacy, which could "upon reasonable grounds" require the registrant or applicant to submit to these examinations by licensed healthcare providers designated by the board and those results would then be admissible in any hearing before the board. The changes will be inserted in O.C.G.A. § 26-4-28 and at O.C.G.A. § 26-4-60. This legislation passed the House and Senate and was signed by the Governor on May 12, 2011 as **Act Number 175**. These amendments included in this law took effect on July 1, 2011.

SB 93 – Sen. Buddy Carter (R-Pooler) also authored this Bill updating Georgia's dangerous drug list in Chapter 13 of Title 16. In the Senate Health and Human Services Committee, "bath salts" were also added to this listing and it also make pseudoephedrine products an exempt, over-the-counter drug which would not be required to undergo the formal rule making process by the board of pharmacy to have the exemption take place in O.C.G.A. § 16-13-29(5). This initiative passed both the House and Senate and Governor Deal signed the legislation into law on May 13, 2011 as **Act Number 228**. The legislation took effect upon Governor Deal's signature.

Professions' Licensure

HB 145 – Rep. Matt Hatchett (R-Dublin) proposed an amendment to the "Georgia Physical Therapy Act" by adding the language "including but not limited to dry needling" in regards to the definition of physical therapy. This Bill amends O.C.G.A. § 43-33-3 and was favorably recommended by the Senate Health and Human Services Committee. It passed the House and Senate and was signed by the Governor on May 12, 2011 as **Act Number 194**. The changes took effect on July 1, 2011.

HB 147 – Rep. Ben Watson (R-Savannah) introduced this initiative to amend the "Patient Right to Know Act of 2001" in Chapter 34A of Title 43. The Bill requires a doctor to include information as to whether he or she has medical malpractice insurance as part of the physician profile. It further requires that the Board compile a report for the Governor and General Assembly

containing statistical and comparative data analysis using information obtained from the physician profiles in addition to other information collected (the information would include information such as numbers of physicians for which it has created profiles; specialty board certification of physicians; geographic regions of the primary practices; numbers of doctors participating in Medicaid; and numbers of physicians carrying medical malpractice insurance and the specialty and current hospital privileges of the physicians not carrying such insurance and whether those physicians are actively seeing patients). It was passed and signed into law by the Governor on May 12, 2011 as **Act Number 108**. This Act took effect on July 1, 2011.

HB 247 – Rep. Jay Neal (R-LaFayette) dropped this Bill which would authorize the Department of Community Health to require fingerprinting and criminal background investigations of all applicants for licensure and currently licensed emergency medical services personnel in Title 31. The Bill passed the House Public Safety and Homeland Security Committee *but* did not make it out of House Rules. See SB 76 which was passed and signed into law.

HB 263 - Rep. Ron Stephens (R-Savannah) authored this Bill adding Article 16 in Chapter 7 of Title 31 to regulate individuals who practice as "surgical technologists." Specifically, it would require that these individuals meet at least one of the following criteria to practice as such: "(1) Has successfully completed a nationally accredited educational program for surgical technologists and holds and maintains the Certified Surgical Technologist credential administered by the National Board of Surgical Technology and Surgical Assisting or its successor; (2) Has completed an appropriate training program for surgical technology in the United States Army, Navy, Air Force, Marine Corps, Coast Guard, or Public Health Service Commissioned Corps; (3) Provides evidence that the person was employed to practice surgical technology in a health care facility on January 1, 2012; or (4) Is in the service of the federal government, to the extent the person is performing duties related to that service." This measure remained in the House Health and Human Services Committee.

SB 66 – Sen. Buddy Carter (R-Pooler) submitted this amendment to Chapter 34 of Title 43. The Bill

would revise continuing education requirements for clinical perfusionists, change the definition of "perfusion," and add requirements related to renewal of licenses for clinical perfusionists. SB 66 was favorably recommended by the House Health and Human Services Committee but it never made it to the House floor. However, the language from SB 66 was inserted into SB 100 which passed and was signed as **Act Number 247**.

SB 135 – Sen. David Shafer (R-Duluth) introduced this piece of legislation which would amend O.C.G.A. § 43-9-18 to clarify that no person other than a doctor of chiropractic may render chiropractic services, adjustments, or manipulations. The Bill passed both the House and Senate and was signed into law by Governor Deal on May 12, 2011 as **Act Number 183**. The changes became effective on July 1, 2011.

SB 251 – Sen. David Shafer (R-Duluth) authored this Bill which transitions annual renewal licensure requirements to a biennial renewal of licenses of agents, agencies, subagents, counselors, and adjusters in Chapters 8 and 23 of Title 33. It further provides for adjustment of licensing fees as necessary to accommodate biennial licensing. This does not alter the fee associated with the licensure of a health maintenance organization in O.C.G.A. § 33-8-1(1)(J) (either its original license or renewal fee which will still occur on an annual basis). SB 251 was signed into law by Governor Deal on May 12, 2011 as **Act Number 220**. The revisions took effect upon signature.

Public Health

HB 214 – Rep. Mickey Channell (R-Greensboro) proposed this initiative to move the Division of Public Health from the Department of Community Health and create a standalone department for Public Health in Chapter 2A of Title 31 with the same functions that the division currently has. The initiative cleared the Senate on March 31, 2011 with an amendment made by Sen. Johnny Grant (R-Milledgeville) in the Senate Health and Human Services Committee. The amendment added the language from Rep. Sean Jerguson's (R-Woodstock) Bill, HB 378, which creates a Hemophilia Advisory Board to help provide expert advice to the state on health and insurance policies, plans, and programs with persons with bleeding disorders and hemophilia. The House agreed on March 31, 2011 to the Senate's changes and Governor Deal signed the initiative as **Act**

Number 244 on May 13, 2011. This Act became effective on July 1, 2011.

Scholarships

HB 325 – Rep. Earl Ehrhart (R-Powder Springs) introduced these changes to student scholarship organizations and the qualified education income tax credits in Chapter 2A of Title 20 and Chapter 7 of Title 48. The Bill passed and was signed by Governor Deal as **Act Number 170** on May 11, 2011; the changes took effect on July 1, 2011. These changes include:

- Amendments to O.C.G.A. § 20-2A-1(1) and definition of "eligible student" which will now mean "a student who is a Georgia resident enrolled in a Georgia secondary or primary public school or eligible to enroll in a qualified first grade, kindergarten program, or pre-kindergarten program; provided, however, that if a student is deemed an eligible student pursuant to this paragraph, he or she shall continue to qualify as such until he or she graduates, reaches the age of 20, or returns to a public school, whichever occurs first."
- Amendments to O.C.G.A. § 20-2A-1(2) and the term "qualified school or program" so as to now include a pre-kindergarten program
- A student scholarship organization will now have to obligate at least 90 percent of its donations for scholarships or tuition grants.
- The maximum scholarship amount awarded by the student scholarship organization in any given year will not be able to exceed the average State and local expenditures per student in fall enrollment in public elementary and secondary education.
- Notices are required in O.C.G.A. § 20-2A-7 so that the Department of Revenue must notify the organization when it has failed to comply with the Code provisions and the Department of Education will remove the entity from its list.

HB 326 – Rep. Doug Collins (R-Gainesville) authored this Bill for the Administration which has a number of revisions in Chapter 3 of Title 20 to comprehensively reform the HOPE Scholarship and Grant program. It includes a provision where all valedictorians and salutatorians from Georgia's High Schools are awarded the Zell Miller

Scholarship, which has been changed from a 3.7 GPA requirement to a 3.3. Remedial class coverage has been maintained for Technical College students, however not for Community Colleges. Also, more rigorous high school academic work will be implemented over the next four years, taking effect in 2015, ensuring that the most well prepared students are benefitting from the HOPE Scholarship. Current proprietary schools are still grandfathered into the legislation; however, it stipulates that no more proprietary schools may be added. Additionally, Lottery bonuses will now be tied into the amounts paid into the lottery, capping at 25%. The bonuses will then be paid out at a 1% net increase, ensuring that before any bonuses are paid out, there are clear incentives for people to "buy in." HB 326 passed the House and Senate and was signed into law by Governor Deal on March 15, 2011 as **Act Number 3**. Its provisions took effect on that date.

State Health Benefit Plan

HR 810 – Rep. Carl Rogers (R-Gainesville) authored this Resolution to create the House State Health Insurance Plan Alternative Funding Study Committee. The rapidly rising health insurance premiums are impacting State budgets, and the State's fiscal pressures are leading to the need to encourage proposals to change funding and cost sharing. This Study will be conducted by seven members of the House of Representatives and they will be required to provide a report on or before December 1, 2011 with any findings and suggested recommendations for legislation. This Resolution was adopted by the House on April 14, 2011.

State Purchasing and Use of State Funds

HB 290 – Rep. Mike Cheokas (R-Americus) proposed this initiative addressing use of State purchasing cards and to apply fraud protection provisions to all State entities, including State authorities, in O.C.G.A. § 50-5-83 by inserting a new definition for the term "agency." Penalties for offenses remain in place. The House and Senate passed this legislation unanimously. Governor Deal signed HB 290 into law on May 11, 2011 as **Act Number 94**. The legislation, as passed and signed, took effect on July 1, 2011 and applies to offenses committed on or after that date.

Taxes

HB 117 – Rep. Rick Crawford (D-Cedartown) introduced this piece of legislation which would amend Titles 31 and 48. It originally amended O.C.G.A. § 48-7-128(b). The Senate Finance Committee used this initiative to add additional language at O.C.G.A. § 31-8-152.1 for an amendment to establish a segregated account within the Indigent Care Trust Fund for revenues raised through sales and use taxes on charges made for services by a person which are the subject of a referral from a SOURCE Case Management Provider. The amendments made by the Senate were at the urging of the Georgia Health Care Association. The Conference Committee on the Bill came up with language for O.C.G.A. § 48-8-2(H):

(H)(i) Charges made for services by a person which are the subject of a referral from a SOURCE Case Management Provider. (ii) This subparagraph shall stand automatically repealed on the date the state treasurer certifies in writing to the commissioner that federal matching funds have ceased to be available or on June 30, 2014, whichever date is earlier.

In revising the definitions for "SOURCE Case Management Provider" and "Referral from a SOURCE Case Management Provider," the language referencing inpatient and outpatient hospitals was removed from those definitions and the nursing homes language was kept. The money in the segregated account would be used for the sole purpose of "obtaining federal financial participation for medical assistance payments for long-term care services including nursing home services." However, the collection of State sales and use taxes would not commence until the Commissioner of Community Health receives approval from the Centers for Medicare and Medicaid Services ("CMS"). Thus, the Bill passed both the House and Senate and was signed by Governor Deal on May 13, 2011 as **Act Number 238**. The language from this legislation took effect immediately but awaits formal approval by CMS. There is a continuing active discussion about whether this financing mechanism can be used to supplement reimbursement rates for certain nursing home and case management services.

HB 168 – Rep. David Knight (R-Griffin) authored this piece of legislation to define the terms "Internal Revenue Code" and "Internal Revenue

Code of 1986" and thereby incorporate certain provisions of the federal law into Georgia law in Title 48. The Bill would also make it so that certain corporate income tax elections made for federal income tax purposes would also apply for state income tax purposes. It was the update to Georgia's Streamline Sales Tax provisions which were created in HB 1221 in 2010. Among other revisions included in this Bill are:

- A definition for the term "dietary supplement" in O.C.G.A. § 48-8-2 "(11.1) which is any product, other than tobacco, intended to supplement the diet that: (A) Contains one or more of the following dietary ingredients: (i) A vitamin; (ii) A mineral; (iii) An herb or other botanical; (iv) An amino acid; (v) A dietary substance for use by humans to supplement the diet by increasing the total dietary intake; or (vi) A concentrate, metabolite, constituent, extract, or combination of any ingredient described in this subparagraph; (B) Is intended for ingestion in tablet, capsule, powder, softgel, gelcap, or liquid form, or if not intended for ingestion in such a form, is not represented as conventional food and is not represented for use as a sole item of a meal or of the diet; and (C) Is required to be labeled as a dietary supplement, identifiable by the 'Supplements Facts' box found on the label as required pursuant to 21 C.F.R. Section 101.36." This "dietary supplement" is now incorporated in the definition of "food and food ingredient" in O.C.G.A. § 48-8-2(16).
- A definition for the term "over-the-counter drug" at O.C.G.A. § 48-8-2 (20.1) which means a drug that contains a label that identifies the product as a drug as required by 21 C.F.R. Section 201.66. The 'over-the-counter drug' label includes: (A) A 'Drug Facts' panel; or (B) A statement of the 'active ingredient(s)' with a list of those ingredients contained in the compound, substance, or preparation."
- It also includes at O.C.G.A. § 48-8-2"(39.1) a definition for "tobacco" which means "cigarettes, cigars, chewing or pipe tobacco, or any other item that includes tobacco."
- The definition of "prosthetic device" in O.C.G.A. § 48-8-2(29) is also amended so that such does not include hearing aids.
- Revisions were also made in the exemptions to the sales and use taxes

found in O.C.G.A. § 48-8-3 including those found in:

- Paragraph (12) so that the school lunch exemption now reads: "Food and food ingredients and prepared food sold and served to pupils and employees of public schools as part of a school lunch program."
- Reinstatement of Paragraph (52), "the sale and use of hearing aids" so that these items are now exempt from collection of sales and use tax.
- Paragraph (54) relating to durable medical equipment so that it now reads, The sale or use of any durable medical equipment that is sold or used pursuant to a prescription or prosthetic device that is sold or used pursuant to a prescription (rather than "prescribed by a physician").
- Paragraph (57) so that it now reads, "(A) The sale of food and food ingredients to an individual consumer for off-premises human consumption, to the extent provided in subparagraph (B) of this paragraph." (B) For the purposes of this paragraph, the term 'food and food ingredients' as defined in Code Section 48-8-2 shall not include prepared food, alcoholic beverages, or tobacco as defined in Code Section 48-8-2 drugs, or over-the-counter drugs. (C) The exemption provided for in this paragraph shall not apply to the sale or use of food and food ingredients when purchased for any use in the operation of a business."

The Bill passed the House and Senate and was signed into law as **Act Number 46** by Governor Deal on April 27, 2011, and the proposal took effect on the date of signature.

Trauma and Trauma Care Funding

HB 307 – Rep. Ben Harbin (R-Evans) authored this initiative which amends O.C.G.A. § 31-11-100, the Georgia Trauma Care Network Commission. The Bill permits a burn trauma center and trauma burn patient to be part of this Commission and eligible for reimbursement. HB 307 passed the

House and became law on May 5, 2011 when Governor Deal signed it as **Act Number 58**. The changes took effect on July 1, 2011.

SB 76 – Sen. Jeff Mullis (R-Chickamauga) offered this initiative which amends O.C.G.A. § 13-11-102 so as to permit out-of-state hospitals, as approved by the commission, where patients are transported to designated trauma centers that are located out of state, to access funding for emergency medical services provided to those patients. This change would help for instance Erlanger Hospital in Chattanooga. It also requires in O.C.G.A. § 31-11-51 that the Department of Community Health obtain conviction data on persons applying for initial licensure as emergency medical services personnel. Further, the Department is also to request fingerprint information from the Georgia Crime Information Center and FBI for each emergency medical services personnel applicant. SB 76 passed the House and the Senate and was signed into law by Governor Deal on May 12, 2011 as **Act Number 174**. The revisions included in this legislation took effect on July 1, 2011. [HB 247 was another bill on this issue regarding background checks for emergency services personnel but it did not pass.]

OVERVIEW OF STATE'S BUDGET FOR FY 2012

Governor Deal signed the FY 2012 Budget, HB 78, on May 12, 2011 as **Act Number 223**. This Budget went into effect on July 1, 2011. In signing this Budget, Governor Deal line-item vetoed several bond indebtedness items relating to funding for projects for the Board of Regents or various technical colleges. Bond funding for the State's water initiatives and the Savannah Port, however, remained intact. This Budget is an \$18.2 billion Budget, and it is approximately 14 percent less than what was spent in 2009. In addressing the State's needs, the General Assembly also tackled the enormous shortfall in the State Health Benefit Plan (almost \$275 million), which is the plan covering State employees and teachers healthcare costs.

The Department of Community Health, which houses Georgia's Medicaid, "SCHIP" or PeachCare for Kids Program and the State Health Benefit Plan, struggled this year with funding, similar to other departments. No money is added in the Department's funding for enrollment growth

for this fiscal year and moves approximately \$80 million to other areas of State government – thus, it will not be adequately funded (depending on enrollment growth) until the amended budget in the 2012 Session. In its managed care initiative, this fiscal year's budget contains only 11 months of the capitation payments which means that in FY 2013, lawmakers will be required to fund the twelfth month. Funding the Medicaid program, in part, is the Hospital Provider Tax of approximately \$224 million (this tax expires in its third year, or 2013). If one were to compare funding from FY 2009 to FY 2012, the Department's Medicaid and PeachCare for Kids programs have seen a reduction of \$278 million (but the Hospital Provider Fee shortfall has been restored). Prior reserves held by the State Health Benefit Plan have been exhausted previously to help balance the State's Budget. Now, employees will have to contribute additional money for their healthcare coverage, seeing additional premium increases in the coming calendar year. The State Health Benefit Plan, though, will likely see a deficit based on projections of \$140 million in this fiscal year (based on declining payrolls, more retirees, etc.).

Education spending for K-12, the universities, colleges and technical colleges was a hot topic, especially in the wake of the Lottery funding and overhaul of the Pre-K and HOPE scholarship and grant funding. Education spending encompasses 53 percent of the total State budget. There were cuts made again in this year's Budget, despite the increased enrollment growth at all levels of the State's education system. Under Georgia's Pre-K Program, there is approximately \$53 million cut from this area (from the FY 2011 funding level) which is funded entirely with Lottery Funds and leaves this funding now at approximately \$300 million. Quality Basic Education ("QBE") Program in K-12 education funding continues to be the largest expenditure area – this includes \$76 million in State funding for enrollment growth and teacher training. There were some additional "adds" in K-12 for the "Move on When Ready" initiative and moneys for the newly certified math and science teachers. In Education, there was not any replacement of the ARRA funding (for Education, that means that this Department did not get replacement money for the \$141 million it had received). Otherwise, QBE received a cut of \$110.6 million (from what was spent in FY 2011); other cuts were made in areas such as School Nurses (a \$1.1 million cut), Nutrition (\$2.5 million), Special Needs

Scholarships (\$1.7 million), and Pupil Transportation (approximately \$8.3 million). Meanwhile, the Board of Regents suffered a cut of \$174 million (compared to its FY 2011 funding), with the bulk of that cut made to the "teaching component" area and there was also no money for enrollment growth projections.

\$11.7 million in State funding was added to the Department of Human Services' Budget for this fiscal year, and \$9.6 million of those moneys will be used for expenses for the State Health Benefit Plan, employee retirement system, unemployment insurance and technology items. Between FY 2009 and FY 2012, there have been reductions of almost 24 percent in the Department of Human Services' funding. In this year's Budget, there were \$15.3 million in State funding cuts made which were needed to satisfy the federal "Temporary Assistance for Needy Families" ("TANF") "Maintenance of Effort" ("MOE") requirements. As a result, the Department will lean on third-party private moneys to cover this "need" for MOE. In finalizing this year's Budget, the Conferees agreed to restoring \$2.8 million in the aging services program area (this will include funding for Meals on Wheels, Center for Visually Impaired, Non-Medicaid Home and Community-Based Respite Services, and Alzheimer's Respite Care Services). In the "pie" for this year's funding for this Department, child welfare and its related services will use 38 percent of the total funding in this Department (note: that from FY 2009 until this fiscal year, the Division of Family and Children's Services have received funding decreases of \$90.2 million with *some* of that money restored with federal TANF funding – Out of Home Care saw a net cut of \$6 million (some of that is due to decreased utilization)).

With the passage of HB 214, the Budget now recognizes a new Department of Public Health. Funding for public health moves from the Department of Community Health to this new Department which receives \$174 million to fund its operations along with an additional \$12 million from the Tobacco Settlement. As noted below, one of the bigger cuts in this Department was a cut of \$2.9 million to eliminate State funding for the Children's First program; rather, this program will receive \$2.8 million in "TANF" funds to be used to fund the program.

We have highlighted a few of the portions of the Budget relating to health and human services in this Report below.

Department of Behavioral Health and Developmental Disabilities

The Conferees agreed that funding for the Department of Justice settlement agreement was paramount. Thus, there were no reductions to those proposals in this agency area.

- Adult Developmental Disabilities Services
 - \$12.8 million is included to increase funding for 400 family supports, five crisis respite homes, and six mobile crisis teams to serve developmental disabilities consumers in community settings.
 - More than \$7 million is included to increase funding to annualize the cost of the FY 2011 150 waiver slots for the New Options Waiver ("NOW") and Comprehensive Waiver ("COMP") for the developmentally disabled.
 - Another \$7.4 million is included to increase funding for an additional 250 waiver slots for the NOW and COMP waivers for the developmentally disabled.
 - A reduction of almost \$2.3 million is taken to reflect "savings" from serving fewer consumers in institutions by closing one state hospital (the House and Senate added that this "savings" would be achieved by moving hospital patients into community services).
 - Conferees also agreed to increase funds for six months for additional New Options Waivers/Comprehensive Supports Waivers to serve youth aging out of Division of Family and Children's Services' care.
- Adult Mental Health Services
 - \$32 million was added to increase funds for mental health consumers in community settings.
 - More than \$7.3 million was included in State funds to replace funding lost from the ARRA funding enhanced FMAP rate.

- Child and Adolescent Developmental Disabilities
 - The proposed reduction of funding for the Marcus Institute provided in HB 948 (in 2010) was restored by Conferees in the amount of \$235,000.
 - A reduction of State funding in the amount of \$649,249 was taken, reflecting an increase in the FMAP from 65.80% to 65.95%.

Department of Community Health

In the Department of Community Health, there were a number of changes made, some of which included:

- Departmental Administration and Program Support
 - A reduction of more than \$5.8 million was made for computer contracts to reflect savings from the transition to a new Medicaid Management Information System ("MMIS") vendor.
 - More than \$19 million was transferred to the new Department of Public Health Departmental Administration program.
- Health Care Access and Improvement
 - An additional \$1 million was added to increase funds for an additional Federally Qualified Health Center in Putnam County and a behavioral health integrated Federally Qualified Health Center in Rockdale County.
 - \$530,064 in funding was transferred in this area to the new Department of Public Health Administration program for Health Share Volunteer Unit.
- Healthcare Facility Regulation
 - A reduction of \$90,921 was made to eliminate funds for the Adult Day Care licensure.
- Aged, Blind and Disabled
 - The proposed one percent provider rate cut was altered by Conferees which moved the rate cut to .5% for all providers except hospitals, skilled nursing facilities and home and community based services.

This reduction will be more than \$1.5 million in State funding.

- Conferees restored the proposed eliminations of funding for "optional" benefit coverage for adult vision, dental and podiatry services.
- Conferees reflected an increase in funds of \$6.5 million State funds of Medicaid fraud settlement.
- An increase of \$545,543 (State funds) was made for 33 slots in the Independent Care Waiver Program to address the community waiting list.
- Conferees did *not* agree to increase funding by \$2.7 million State funds to transition Medicaid eligibility from six month reviews to 12 month reviews while requiring clients to report changes in their status outside of the review time.
- Conferees added language, but no money, to authorize the Department, through revenue generated by HB 117, to increase provider reimbursement rates for nursing facilities and also long-term care services case-managed through the SOURCE program.
- Low-income Medicaid
 - The proposed one percent provider rate cut was altered by Conferees which moved the rate cut to .5% for all providers except hospitals, skilled nursing facilities and home and community based services. This will "save" approximately \$3.18 million in State funds.
 - Conferees restored the proposed eliminations of funding for "optional" benefit coverage for adult vision, dental and podiatry services.
 - Conferees agreed to reducing funds by increasing existing member co-payments. This results in a savings of \$360,456 in State funds.
 - Conferees did *not* agree to increase funding to transition Medicaid eligibility from six month reviews to 12 month reviews while requiring clients to report changes in their status outside of the review time.

- Conferees agreed to increase by \$1.3 million State funds for the "Express Lane" eligibility project which will simplify the Medicaid enrollment process.
- PeachCare for Kids
 - The proposed one percent provider rate cut was altered by Conferees which moved the rate cut to .5% for all providers except hospitals, skilled nursing facilities and home and community based services. This will "save" approximately \$349,622 in State funds.
 - Conferees did *not* agree to reduce funds by including the 2.25% premium tax within the existing administrative percentage for CMOs' cap rate range development and implement a minimum Medical Loss Ratio of 87%.

- More than \$2.5 million will be reduced for supplemental funding for the nutrition program.
- Pre-School Handicapped
 - \$574,851 will be taken in this funding based on declining enrollment (these moneys are used to provide early educational services to three and four-year old students with disabilities so that they may enter school better able to succeed).
- School Nurses
 - Funding in the amount of more than \$1 million was cut for these nurses.
- Severely Emotionally Disturbed
 - A cut of \$1.29 million was taken because of declining enrollment.
- Tuition for Multi-Handicapped
 - A reduction of \$15,676 was made in this area (this is the money to reimburse school systems for private residential placements when the school system is unable to provide an appropriate program for a multi-handicapped student).

Department of Education (relating to health issues)

- Non Quality Basic Education Formula Grants
 - Originally, Governor Deal proposed more than \$709,000 to be reduced from the funding for Residential Treatment Centers around the State (which help fund the local share of educational needs for these children who are in State custody); Conferees restored all but one percent of the funding, making the reduction \$38,701.
 - Sparsity grants will be reduced by \$298,331.
 - Conferees opted to reduce the funding for Georgia Special Needs Scholarship to reflect austerity consistent with total QBE austerity and provide forward funding for enrollment increases and balance funding using mid-year FTE counts. This reduction will be \$1.73 million.
 - A \$30,000 reduction in funding for high performing principals will be taken.
 - There is an elimination of funding for migrant education grants in the amount of \$249,113.
- Nutrition

Department of Human Services

In the Human Services' portion of the Budget, under Section 27 of HB 78, the Department will utilize in FY 2012 a total of more than \$1.596 billion (with State and all other federal funds) to meet that entity's efforts. There were several entries which were common throughout the Department's funding which reflect changes, for instance, on Employees' Retirement, workers' compensation, and State Health Benefit Plan needs. Further, Conferees made changes to address the loss of American Recovery and Reinvestment Act ("ARRA") money including the enhanced Federal Medical Assistance Percentage ("FMAP") funding. Some of the highlights from this Budget area include:

- After School Care – received an increase of \$1.5 million in funding from TANF (rather than what was proposed by the Governor and House at the rate of \$3.68 million "based on projected expenditures").
- Child Care Services – a couple of noteworthy entries in this program area were

- A reduction of more than \$45 million because of the expiration of ARRA funding.
- An increase of \$1.33 million to fund 400 new child care slots.
- Child Welfare Services – several changes were made in this program and include in particular the elimination of the funding for the EMBRACE contract in the amount of \$173,250 in State funds.
- Departmental Administration
 - Replacement of \$99,032 in State funds for transportation services of elderly consumers with Social Services Block Grant funds in that same amount.
- Elder Community Living Services
 - Conferees restored three contract reductions (Center for the Visually Impaired; Alzheimer's Respite Services; and non-Medicaid home community based respite services).
 - Added more than \$10.5 million reflecting the loss of ARRA funding.
- Elder Support Services
 - An addition of \$1,045,000 in State funds was added for increasing funding for Meals on Wheels.
- Family Violence Services
 - Originally, the funding of \$4.48 million in State funds was to be replaced with TANF funding for the Sexual Assault Centers. Conferees amended this amount, reducing the State funding by \$3.8 million and adding TANF funding of \$4.48 million, but placing language to "administer funds in the most efficient and timely manner."
 - Conferees also added \$1 million to serve "non-TANF eligible victims of domestic violence and sexual assault. These funds are not to be leveraged by any state agency as maintenance of effort or state match towards federal funding which would inhibit the ability of providers to serve the broadest population possible."
- Federal Eligibility Benefit Services
 - House members had proposed to transfer \$1.3 million to the Department of Community Health for the "Express Lane" eligibility project to simplify the Medicaid enrollment process. Conferees did not transfer any funding and included that the Department is "authorized to work with the Department of Community Health in implementing the 'Express Lane' eligibility project."
- Support for Needy Families – Basic Assistance
 - Conferees agreed to reduce funding to reflect prior year expenditure trends.
 - Conferees also reduced from the TANF Grant more than \$5 million and added TANF Unobligated Balance per 42 USC 604 funding in that same amount.
- Support for Needy Families - Work Assistance
 - More than \$3.57 million is reduced from State general funds for employment support activities based on decreased utilization.
 - An addition of \$3.57 million was added in TANF grant funding to reflect projected expenditures.

After the Session's conclusion, we have learned that the Department will be looking for additional "MOE" opportunities as it is apparently \$16 million short from the required amount.

Department of Labor

- Division of Rehabilitation Administration
 - Governor Deal proposed to reduce funding of contracts by \$243,129. The Senate restored dollars for the Georgia Council for the Hearing Impaired, moving the reduction to \$103,295, but Conferees took the entire cut of \$243,129 from this area.
- Georgia Industries for the Blind
 - A cut of \$31,787 is made in funding personnel.
 - Conferees reduced funding by \$294,206 in an effort to move the program to self-sufficiency using agency generated income.
 - Conferees did agree that this program area would be assessed administrative fees by the Department.
- Vocational Rehabilitation Program
 - Conferees chose the Governor's position to reduce contract funding by \$391,362.
 - Conferees also went with the Governor's position to reduce one-time funding for the Georgia Talking Book Center as provided in HB 948 (from 2010 Session) in the amount of \$24,287.
- A reduction of funding in the amount of \$21,890 for Georgia Public Health Laboratory testing that is duplicative of private sector services (this cut will not impact screenings for newborns).
- Immunization
 - Conferees added language to redirect \$1 million in Maternal and Child Health Block Grant Funds to provide immunization, consultation, training, assessment, vaccines and technical assistance under the immunization program.
- Infant and Child Essential Health Treatment Services
 - The original proposed cut of \$450,000 to programmatic grant-in-aid to County Boards of Health had a restoration of funds by Conferees for infant and child oral health services, bringing the reduction to \$167,798 in this funding.
 - The \$2.9 million reduction for the discontinuation of the Babies Born Healthy program remained.
 - Language was added to restore \$250,000 to the Governor's recommended reduction and transfer an \$80,263 reduction from the Adult Essential Treatment Services program (by moving hemophilia clients to PECIP contracts).

Department of Public Health

Under the Department of Public Health, now included in Section 37 of HB 78, some of its proposed funding included:

- Adolescent and Adult Health Promotion
 - A reduction of \$35,732 for programmatic grant-in-aid to County Boards of Health
- Adult Essential Health Treatment Services
 - Cut of \$600,000 in State funding to reflect contract changes by moving high cost hemophilia clients into federal PECIP plans and reflecting an additional \$80,263 reduction in the Infant and Child Essential Health Treatment Services Program.
- Epidemiology
 - A reduction of \$141,215 was made for programmatic grant-in-aid to County Boards of Health
- Infant and Child Health Promotion
 - The Governor's proposed reduction of \$653,124 for hemophilia clients moving to PECIP was reflected in the Infant and Child Essential Health Treatment Services program area.
 - No additional funding of \$1.5 million was made, as proposed by the House, for funding the Children's 1st program. Rather an additional \$2.8 million from TANF funding will be used.

MESSAGE FROM THE EDITOR CALL FOR AUTHORS

The Health Law Section of the State Bar of Georgia is pleased to provide a publication for its members to address current topics of interest. We encourage you to send us summaries of recent cases, legislation, and agency activities that may be of interest to health law attorneys who practice in Georgia and the Southeast. Suitable short feature articles on timely topics may also be accepted for publication. Please address inquiries, submissions, and suggestions to:

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